MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING

Reporter's Transcript of Afternoon Proceedings

Friday, December 12, 1997
(1:00 p.m.- 8:23 p.m.)

Chamber of Commerce Building
1201 K Street
12th Floor Conference Room
Sacramento, California

Reported By: Sandra L. Hopper, CSR 7110

A P P E A R A N C E S

Members Present:

Alain Enthoven, Chairman
Clark Kerr, Vice-Chairman
Philip Romero, Executive Director
Alice Singh, Deputy Director
Bernard Alpert
Rodney Armstead
Rebecca Bowne
Donna Conom
Barbara Decker
Nancy Farber
Jeanne Finberg
Hon. Martin Gallegos
Bradley Gilbert
Diane Griffiths
Terry Hartshorn
William Hauck
Mark Hiepler
Michael Karpf
J.D. Northway
Maryann O'Sullivan
John Ramey
Anthony Rodgers
Helen Rodriguez-Trias
Les Schlaegel
Ellen Severoni
Bruce Spurlock
David Tirapelle
Ronald Williams
Allan Zaremberg
Steven Zatkin

Ex-Officio

Kim Belshe
Marjorie Berte
Keith Bishop
Chuck Quackenbush
Michael Shapiro
David Werdegar

P R O C E E D I N G S

CHAIRMAN ENTHOVEN: Welcome back for lunch. Thank you all for not fleeing to the airport. I'm -- if my behavior seems to be a little unpredictable or erratic, I'm juggling with all these messages that came in. A little while ago I got a message that three Members are stuck at the Burbank Airport: Dr. Karpf, Hartshorn and Severoni. And so I thought wonderful when I saw Dr. Karpf, that that meant we would see Hartshorn and Severoni. But it turns out -- they could be on two totally different planes.

So I'm thinking this is probably a good or appropriate time for us to take on regulatory oversight. So I would suggest that we first take up the Government regulatory oversight and offer here an example of what I was mentioning earlier in terms of streamlining our process. And that is this is an idea I formulated in my head and had in mind even before I had an idea as to what the fog was likely to do to our attendance. If you recall, we need 16 votes to pass anything.

We've had a lot of exchange of ideas and memos about whether the regulatory agency should be headed by a single individual or by a board and then various (inaudible) on the board idea.

I would like to suggest to the Task Force that we simply agree among ourselves we probably

aren't going to get 16 votes either way is point one about it. If everyone were here, it looked to be like it was going to be very close one way or another, kind of a razor's edge situation. And that's what led me to feel it would be inappropriate for us to make a recommendations based on 16/14 one way or another at least without somehow reporting this is very close.

But what I wanted to suggest is that -- for your consideration, is that we just decide not to take a stand on that issue, and say this agency should be headed either by a single appointed leader or by a board to be determined by the Governor and the Legislature, which is what they're going to do anyway.

Also, this is a very politically freighted issue, and it's one on which the expertise of many of us who are -- whose expertise grows out of health care more than the fine points of how to organize the Government. So when we get to that, I'm just going to suggest that we consider not taking a stand on that issue, and we might save ourselves a lot of time.

MEMBER GALLEGOS: Mr. Chairman?

CHAIRMAN ENTHOVEN: Yes.

MEMBER GALLEGOS: If I could just be allowed to respond to that. I think that if the Task Force chooses -- and it's up to them -- to

take that recommendation, I think that we shirk a tremendous responsibility that we've been legislated to provide. I don't see why that one particular issue out of all of the issues that we've dealt with is going to be an issue that we're going to decide to not deal with because it's too politically sensitive or it's too hot an issue or for whatever reason, you know, you're proposing that.

CHAIRMAN ENTHOVEN: Well, I just stated the reasons.

MEMBER GALLEGOS: But we were, by legislation, formed in order to make these kinds of recommendations. And I think if we do that -- if we do what you've proposed, Mr. Chairman, with all due respect, I think that we're not doing justice to what we came and were appointed here to do. I mean if we're going to pick and choose certain issues and say, well, we're not going to deal with that one because, you know, we're getting pressure from the Governor or we're getting pressure from one side or the other, then I think we have violated the spirit of what this Task Force was formed and intended to do.

Now, again, it's going to be your call, Members, what we decide to do. But I want to just make that statement. And if something leaves this Task Force with the minimum 16 votes, that's

majority rule, Mr. Chairman and Members. And that's what this whole process is about. If the majority decides that this is the best way to go on an issue or not, I mean that's the foundation of democracy. That's what we work with across the street in the Capitol.

So -- I mean I would ask that, Mr. Chairman, either you reconsider that recommendation or that the Board please strongly consider dealing with this. Because the Governor is going to look to this entire report as a plan or a blueprint on how he's going to deal with any legislative reforms that are going to go through the legislative process. And the Legislature is going to do the same thing.

And I think it would be -- I think it would be a disservice to the people of California if this Task Force were not to deal with this issue. And I understand the politics behind it; believe me. Coming from the Legislature, I understand the politics behind it. And -- but I think that we need to step forward and say no, we were formed as a task force for a purpose to make these decisions and to vote on these issues. And we should take that responsibility very seriously when we deal with all of these issues that we've been dealing with over the last seven or eight months.

CHAIRMAN ENTHOVEN: Okay. Well, I certainly didn't intend to suggest anything undemocratic. I was just thinking that no alternative may get 16 votes. We'll see. I mean certainly we'll be voting.

Yes, Nancy.

MEMBER FARBER: I feel really strongly that you shouldn't subject this to a different standard than any other item idea that we're voting on.

CHAIRMAN ENTHOVEN: Okay.

MEMBER LEE: Alain?

CHAIRMAN ENTHOVEN: Yeah.

MEMBER LEE: Could I offer a suggestion? Given that we know this is one of the major issues we need to take up -- and I think I saw earlier that virtually everyone's going to be here tomorrow and many people approximately aren't here today -- I think we've set up a flexible process. I think we'd be better off having more people here. I don't know why -- why don't we deal with this tomorrow when we have closer to 30 than we do now? Is there -- I mean we're sort of setting ourselves up for a hold-open vote, roll calls as opposed to saying tomorrow's there's going to be closer to 30 and have the discussion and votes tomorrow.

CHAIRMAN ENTHOVEN: Okay. Then we'd

need to move some of tomorrow's into today.

MEMBER LEE: Sure. Yeah. That's why we put everything on the agenda for both days, to have the flexibility to do that.

CHAIRMAN ENTHOVEN: Well, why don't we take then --

MEMBER FINBERG: As long as it's early in the day.

MEMBER LEE: What? Pardon?

MEMBER FINBERG: As long as it's early in the day.

MEMBER LEE: Let's deal with it first thing. We've got our morning coffee or whatever.

CHAIRMAN ENTHOVEN: All right. Well, then shall we try physician/patient relationship?

MEMBER FARBER: Could we go back to the academic medical center one which we tabled? Dr. Karpf is here.

CHAIRMAN ENTHOVEN: Okay. Without objection, we'll accede to your desire, Nancy.

Okay. Academic Medical Centers; I think that's 6-C. It's just Findings on the Statutory Paper. I had a brief outline discussion with Dr. Karpf. Where is Dr. Karpf?

MEMBER KARPF: Right here.

CHAIRMAN ENTHOVEN: Oh, there you are. Okay. Welcome, Michael. Nice to have you with

And we had a brief outline discussion about Dr. Gertler's (phonetic) letter. And Dr. Karpf doesn't think we need to undo the general line of thinking that we had this morning, which is to go with what we've got.

So, Michael, the floor is yours to move the Paper, lead the discussion.

MEMBER KARPF: Okay.

CHAIRMAN ENTHOVEN: I was hoping we could get through this one really very quickly because it's been very well worked over.

MEMBER KARPF: Okay. There has been a lot of discussion about this Paper going back and forth between myself and staff and Professor Enthoven over several weeks. It's been a hard Paper because there are lots of sentiments and not as much information as one would like about the impact of managed care on academic health centers.

We've tried to come up with a balanced approach; one that was not patently pro, and one that was not patently against academic health centers.

The issues that Bill Gertler raised were ones of trying to bring some additional balance to it. He tried to raise two issues: One, the fact that the UC system has made some effort in rectifying its approach to training -- and it has.

that to the Paper. That will speak for itself over the long haul. He tried to bring some balance in terms of DHS dollars, and I think that we can easily clean up the language a little bit to, in fact, represent -- to represent his point that not all of the DHS dollars go to the academic health centers; they go some to academic health centers and much to other safety net providers.

So -- and Nancy said that she had some question about one -- about the ending paragraph and said that she would like to raise. After Nancy's discussion, I would move that we adopt this, pending any action on her amendment.

MEMBER FARBER: My issue this morning, which I'll repeat for your benefit, had to do with the sentence in the last paragraph that reads: Health plans feel themselves under pressure to pay for unproven therapies which may waste money and even be harmful to patients.

And my feeling was that if you're going to include that as an argument, then you also have to include the proclivity for health plans to prevent patients from having access to academic medical centers where their health outcomes could actually be improved.

Citing a 1995 study of pediatric heart

performed in 1992 where she found that after adjusting for the riskiness of surgery, patients with regular commercial insurance were less likely to die than those with HMO coverage. The difference being especially pronounced in the largest HMO markets, California. And the conclusion was that the HMOs were less willing to send patients to high-cost hospitals.

If you're going to include one argument, you have to include the other for the sake of fairness.

MEMBER ZATKIN: Question, Mr. Chairman.

CHAIRMAN ENTHOVEN: Yes.

MEMBER ZATKIN: I'm trying to understand the relationship of the point that you just made to this sentence.

MEMBER FARBER: The point is that health plans feel themselves under pressure to pay for unproven therapies which may waste money. They also feel they have a significant proclivity not to send patients to academic medical centers for other reasons than unproven therapy and the fear that that therapy may be harmful to patients. They have a very strong economic incentive not to send patients there; sometimes to the documented

detriment of the patient.

MEMBER KARPF: I think that Nancy

recognizes that as an editorial comment. And I think that if we strike that, that will satisfy --

MEMBER FARBER: Absolutely.

MEMBER KARPF: -- her. I don't think that sentence really adds any substantive effect to that Paper. So I think we should just get rid of that sentence or that part of the paragraph.

MEMBER O'SULLIVAN: I'd like to ask that the following sentence also be stricken. It's as editorial.

MEMBER RODGERS: "With some of the people," is that what sentence you're talking about? Which sentences are we talking about?

MEMBER SCHLAEGEL: "Some people."

MEMBER RODGERS: Okay.

CHAIRMAN ENTHOVEN: Let's see. Without objection we'd strike the first sentence. All right. "Health plans feel." Then what about the second?

DEPUTY DIRECTOR SINGH: Is there an objection to striking the second?

CHAIRMAN ENTHOVEN: We're talking about the first one.

MEMBER SPURLOCK: The second, not the first.

CHAIRMAN ENTHOVEN: What?

MEMBER SPURLOCK: The second, not the first.

CHAIRMAN ENTHOVEN: So we'll discuss the second one now.

MEMBER KARPF: What I would suggest, the value of this paragraph is to point out that there isn't always clarity in terms of standard of care, and there needs to be some mechanisms and occasionally clinical trials. And I think that that can be achieved by essentially keeping "The major problem for managed care in California results from the fact that patients want access to costly therapies. Efficacy has not been substantiated by controlled clinical trials or other convincing evidence." That is, in fact, true of managed care; it's also true for non-managed care for traditional insurance.

If we go to "new treatment modalities need to be evaluated rigorously under carefully designed and controlled clinical trials to establish if they should be included in a standard of care, AFCs in particular have the capacity to do such studies" and finish out that paragraph, I think that will accomplish the thought that was the intent of that paragraph and strike everything in between.

MEMBER BOWNE: So we're deleting three

sentences?

MEMBER DECKER: No, deleting two sentences.

MEMBER KARPF: We're actually deleting --

MEMBER BOWNE: Are we deleting "in some cases this issue becomes extremely controversial"?

MEMBER KARPF: Right. Deleting from there until "new treatment of modalities." It's two sentences.

CHAIRMAN ENTHOVEN: For the record, what do you think?

MEMBER BOWNE: It's the two sentences, starting with "health plans" and concluding with "proposed treatments."

MEMBER NORTHWAY: No, starting with "In some cases." That's one sentence. And "some people" is three sentences.

MEMBER KARPF: It's three sentences. That's really an editorial comment.

MEMBER BOWNE: It's been so butchered, it doesn't matter anymore.

MEMBER KARPF: Right. But rather than add another paragraph to add kind the of balance that Nancy wants, I think we're better off deleting those three sentences.

MEMBER FARBER: I think the remark that

was just made by Rebecca is one that we shouldn't just laugh about and pass over. I don't think that this Paper is in the least bit responsive to what the Legislature and the Governor asked us to do. I

recognize that it is a horrendous compromise that we've achieved at some considerable cost of energy on Dr. Karpf's part. But I don't think we've done our providers and the academic medical centers justice with this Paper. And I don't think that we've done much for consumers in this Paper. Perhaps we've held the line for the health plans. That's about all.

CHAIRMAN ENTHOVEN: Well, let me ask -- let's take a vote on deleting those three sentences.

MEMBER NORTHWAY: I just wonder if Michael could remind us -- and I've forgotten why there are no recommendations with this Paper and only findings.

MEMBER KARPF: There were three recommendations that were originally proposed: One recommendation centered on risk adjustment. That recommendation didn't have to appear here because it has been accepted elsewhere.

The second recommendation that potentially was proposed was some type of analysis of the cost of health care and potentially an all-payor contribution to shouldering the cost of

health care should the ability of academic health centers to cross-subsidize education disappear because of pressures on reimbursement. I decided not to push for that because that is controversial,

and I didn't think that this group was prepared to take that issue on. That would become part of the national agenda, I think, at a future time.

The third issue was the issue of developing standards of care and should payers participate in clinical trials which define the movement of new modalities from experimental care to standard of care rather than having those modalities essentially diffuse into standard of care without hard data to support that. That issue is actually being raised elsewhere under -- in several different chapters. So that disappeared from here.

So we're left with really a descriptive Paper rather -- and sort of fight the battle lines of the other issues in chapters that are more appropriate.

CHAIRMAN ENTHOVEN: Rebecca.

MEMBER NORTHWAY: Is that a problem for us, Alain? Because this is a mandated Paper.

CHAIRMAN ENTHOVEN: This is -- it's not a problem that we don't have recommendations. It is a required Paper.

MEMBER KARPF: We do have one recommendation that there be a study of health (inaudible) in California and that the AFCs be asked to respond to that study.

CHAIRMAN ENTHOVEN: Bruce.

MEMBER NORTHWAY: Say that again.

MEMBER KARPF: There is a request, not necessarily a recommendation that the academic health centers be challenged to study the -- the health-power needs physician as well as other medical professionals, and that they respond to that -- to that study. So that is embedded in here at Donna's recommendation but as a discussion.

CHAIRMAN ENTHOVEN: Okay. Bruce.

MEMBER SPURLOCK: Thank you very much. I think if we take those lines out, we need to refer to the part in the Practice of Medicine Paper where it deals with this issue. I have actually great trouble with the fact that -- and we could reword this, but I think that the Legislature or the courts are not the ways to solve the problem with what's efficacious treatment and what is not experimental. And the best example of that is with the breast implant decision that came out about five years ago. And now multiple studies show there's no linkage between that and musculoskeletal symptoms. So that when the courts make those determinations, they don't have the

benefit of the scientific knowledge.

I would be comfortable by referring to -- if we take those lines out -- not addressing that, but referring to the Paper in the Practice of Medicine where we deal with that subject on how

best to do that, rather than saying what's not good. But I don't think the courts are the appropriate place to make efficacy decisions about experimental therapies.

MEMBER KARPF: I don't think this language speaks to having it done in the courts. But I do think that you're right, referring to it -- referring back to where it is discussed in greater detail is appropriate.

CHAIRMAN ENTHOVEN: Well, there is a sentence here which says neither the courts nor the Legislature are good forums for making these decisions. And so there is a question of whether we strike that or not. I mean perhaps some people feel that sentence ought to stay in. We could vote on that. Let me just --

Rebecca.

MEMBER BOWNE: That's all right. I'll pass.

CHAIRMAN ENTHOVEN: That's okay.

Nancy.

MEMBER FARBER: I feel that Dr. Karpf's

original intention to include in this Paper the question of an all-payor mandated tax of some kind supports medical education should be put back in and at least considered as a recommendation and let it rise and fall on its own merits. It's actually something I feel so strongly about, that I'd like

to see a roll call about it.

I'll repeat what I said at the last hearing: What you're doing at academic medical centers today is tomorrow's future in a community hospital. And historically, whatever the evils you may have seen in the fee-for-service medicine experience that this country's had, it did, in fact, support medical education. And I think that it is so critical to the future of the health and well-being of this country and such -- it's been such an integral part of our preeminence in the world as a medical power, that to just dance right past that issue without ever finding out how the rest of the Commission feels would be a crucial mistake. And I would urge you to put it back in as a recommendation and let it rise and fall on its own merits.

CHAIRMAN ENTHOVEN: Nancy, would you kindly draft a sentence or two that says what you propose?

MEMBER FARBER: Dr. Karpf, could you do that?

MEMBER KARPF: Sure.

MEMBER FARBER: I'm sure he has one already.

CHAIRMAN ENTHOVEN: I'll come back to you in a moment, Michael. First, I just want to deal with this other question. Is there a majority

in favor of removing the sentence "Some people take their demands to court, others to the legislature"?

MEMBER SPURLOCK: Maybe I can offer a suggestion on this line. Perhaps we could say that while not prohibiting people taking their demands or their issues regarding efficacy to court and to the Legislature, it is not the optimum place to make these decisions. Then I think that we meet the needs of the statement that it's really not optimal to do this there. I would never want to prohibit anybody from doing something that's in their legal rights in this country to be able to do.

MEMBER DECKER: Could you say it again?

MEMBER LEE: Are you suggesting deleting "some people take their demands," and say "neither the courts nor legislatures are the ideal forums"?

MEMBER SPURLOCK: That's right. "Are the ideal forums for determination" --

MEMBER LEE: "For evaluating the efficacy of proposed treatments."

MEMBER SPURLOCK: Exactly.

MEMBER LEE: Great.

MEMBER O'SULLIVAN: You know why I don't like that language is because it's going to get pulled out by somebody who's going to say this

Task Force said this stuff shouldn't be at the Legislature on a day when the --

MEMBER SPURLOCK: That's not --

MEMBER O'SULLIVAN: No, let me say it. On a day where no one else has taken responsibility for it. So it ends up in the court and the Legislature. If we think there's better places for these decisions to be made, we ought to say where they are and promote that.

CHAIRMAN ENTHOVEN: That's what the rest of the paragraph is saying is that the appropriate thing is it needs to be evaluated rigorously under carefully designed, controlled clinical style. AFCs in particular advocate the ability to do such studies. So we are saying that.

MEMBER O'SULLIVAN: All right. If they're going to say why the Legislature and the courts aren't good, we ought to be saying what they are good for and why people end up using them.

CHAIRMAN ENTHOVEN: Okay. We could say

lacking scientific expertise, the courts -- neither the courts nor Legislature are the ideal forums.

MEMBER O'SULLIVAN: But often the only forum.

MEMBER LEE: No, they might have expertise. I think it's pretty clear --

CHAIRMAN ENTHOVEN: Well --

MEMBER O'SULLIVAN: The author of this Paper proposed taking -- agreed with the idea of taking the sentence out.

MEMBER BOWNE: Excuse me. He is not the author. He is not the only author nor is he the author.

MEMBER KARPF: No, I'm not the author.

CHAIRMAN ENTHOVEN: Well, I think that -- I mean I'm trying to find a -- you know, accede to reasonable suggestions here, but to have a way of preserving the thought and then giving people an opportunity to express the thought. So let's see. Here is a revised sentence. It would say -- in replacing the sentence, it says "Some people take their demands to court, others to the legislature" -- no, I'm sorry. That goes out. We just begin that sentence with "Lacking scientific expertise, neither the courts nor the Legislature are the ideal forum for evaluating the efficacy of proposed treatments."

MEMBER HIEPLER: I would object to the "lacking scientific expertise." In all of our cases, we have the best experts in the world come to court, and that's what persuades a jury. So -- I mean that's denigrating the process just because it happens to be controversial.

MEMBER LEE: Just lead with "neither" without saying "lacking expertise."

MEMBER O'SULLIVAN: How about this: If we start with "Often lacking other recourse, some people take their demands to court, others to the Legislature, neither of which are the best forum for evaluating."

MEMBER GRIFFITHS: "Often feeling a lack of recourse"?

MEMBER SHAPIRO: Why don't you say what's optimal and not indicate what's suboptimal. Why don't indicate by cross-reference the most optimal way of doing this. And by implication we know that you don't want to go to the Legislature and court if you've got that optimal solution rather than...

VICE-CHAIRMAN KERR: Right. I was going to say leave out the (inaudible), and just start out by saying "The best forum for evaluating efficacy of proposed treatments," blah, blah, blah.

MEMBER HIEPLER: Because that

eliminates the need to solidify that what they promised in the contract regardless of concerns of efficacy is something they've got to deliver and so and so. I don't need to even put that in now since you did that.

CHAIRMAN ENTHOVEN: Well, how many -- is there a sentiment for preserving some kind of statement like that, or should we just let it go?

MEMBER LEE: We don't know what the length of that is, Alain. Unfortunately I'm not sure Rich will like that one you're talking about.

CHAIRMAN ENTHOVEN: Is the idea that the courts and Legislature are not the ideal forums.

MEMBER LEE: I think Michael's suggestion was -- everyone's going to nod their heads to, is to do the positive rather than the negative.

CHAIRMAN ENTHOVEN: That comes up in the next sentences. All right. So let's just delete those three sentences. So let's have a -- okay. Let me take a straw vote on deleting those three sentences. All in favor?

MEMBER FINBERG: Three sentences or --

CHAIRMAN ENTHOVEN: Three sentences that come out begin with "In some cases," then the next one is "health plans," and then the next one

is "some people," ending with "the efficacy of proposed treatments."

MEMBER FINBERG: Okay.

CHAIRMAN ENTHOVEN: And then we just pick up "new treatment modalities need to be evaluated rigorously under carefully designed and controlled clinical trials" and pick it up from there.

MEMBER LEE: Unfortunately -- shouldn't

the burden be on these staying in as opposed to coming out?

MEMBER DECKER: I'm sorry?

MEMBER LEE: Shouldn't the burden, so to speak, be on these staying in as opposed to voting that they come out?

MEMBER DECKER: What does that mean?

MEMBER LEE: Who thinks that these three sentences should be here? This is not a motion on the table.

MEMBER DECKER: Who gives a shit? Let's just vote.

MEMBER FINBERG: Was that a term of art?

CHAIRMAN ENTHOVEN: All right. A straw vote on -- those in favor of deleting, please raise your right hand. The majority of those present favor deleting them.

Michael, did you now have a...

MEMBER KARPF: I'm just about there.

CHAIRMAN ENTHOVEN: You're just about there. I think -- any other points on this Paper? Yes, Donna.

MEMBER CONOM: I agree that this Paper is extremely disappointing, and the recommendations that have been left out I would have liked to have seen them in here. I wonder if we shouldn't kind of go back to the drawing board -- I know it's

going to take some time -- but to pull out some of the good things -- there are good recommendations in the body of the Paper. For instance, managed care organizations and other payers should support such studies. That addresses the issue of research. So I would like to see the good things like that pulled out and made into recommendations to make this a much stronger Paper like the format of the other Papers that we've got.

CHAIRMAN ENTHOVEN: Rebecca?

MEMBER BOWNE: Having suffered through well over -- I can't even tell you how many conference calls. To me, I think we should just leave it at this point. We've got a lot of work to do. The Paper doesn't address health professionals. It only addresses physicians. It leaves out so much, be it in the recommendations or in the substance because it is a very controversial

issue. We are not going to resolve it. And I suggest we adopt it and move on.

CHAIRMAN ENTHOVEN: Nancy.

MEMBER FARBER: I'm going to go back to my original question because I'd like to see this Commission out one way or the other on the subject of medical education. And by that I mean education of physicians and academic medical centers. I really think it is such a critical issue that you've got to come out one way or the other.

CHAIRMAN ENTHOVEN: Well, that's the words that Michael is working on.

MEMBER ZATKIN: Could we discuss the concept even while Michael's working on the words? Because I support Nancy's goal. I don't support an all payor. I support a statement about appropriate, adequate funding for medical education.

The reason I don't support an all-payor system is because it is tied to a system which is essentially voluntary, namely, health insurance, and it loads that up.

I think medical education is a public good. It benefits the whole public and ought to be funded that way. If you fund it as an all-payor system, which means it's tied to health plan premiums, if anybody looks at what's happening with health care coverage, you're going to do two

things: You're going to have declining support for medical education in that sense because coverage has gone down, and premiums are going to go up, which will make coverage go down even more. I don't -- I agree with your goal; I don't agree with the all-payor approach. I would rather say that there needs to be adequate funding for medical education. That's not occurring. And it ought to be funded --

MEMBER FARBER: I think if you say --

CHAIRMAN ENTHOVEN: You know, Michael isn't even claiming that that is not occurring today -- I mean when we discussed that.

Right? You're not saying today -- there may be problems in the future, but are you saying today there isn't adequate funding for education?

MEMBER KARPF: The cost of medical education has been poorly defined in the past. The support for medical education has come through some direct channels and many indirect channels.

MEMBER ZATKIN: And cost shifting.

MEMBER KARPF: And some cost shifting. So Medi-Cal dollars have been essentially channeled towards medical education under the guise of clinical care. There have been some discreet state dollars that have come through medical education. There has been substantial cost shifting from

revenues from private insurance payers to medical education. With the pressure on reimbursement and with the Government decreasing support for medical education in a very clear-cut fashion by decreasing payments for medical education through the Balanced Budget Act, there is increasing pressures on how to support medical education.

From my perspective, one needs to occur. So we need to have an understanding of what the true costs of medical education are, and we need to have a staple revenue base for supporting that.

That is the only way that health plans, HMOs and other payers can start holding academic health centers accountable in terms of clinical reimbursement. You've got to get the cost shifting out of there. You get the cost shifting out of there, you have to have a stable basis to support it.

MEMBER ZATKIN: Rather than say it's inadequate -- because I don't know if it's adequate or inadequate -- say it needs to be appropriately funded and needs a stable revenue base which ought to be funded as a --

MEMBER KARPF: What you're going to have -- because I haven't gotten to the tax part, and then we can argue from there. The education, appropriate training of medical providers so that it encompasses more than physicians. It

encompasses nurses, advanced nurse practitioners, physicians' assistants and other providers is a public good. The financial support for medical education has never been clearly defined. To substantial degree, the cost of medical education has been supported by clinical revenues through cost shifting. As pressure on reimbursement intensifies and clinical revenues are threatened, more discreet funding streams need to be identified. It is in the interest of the public to define a stable revenue stream for medical

education. And we can ask that the cost of -- that a panel be brought together to study the cost of medical education and figure out how to fund it.

MEMBER ZATKIN: I would support that statement.

MEMBER KARPF: What?

MEMBER ZATKIN: I would support that.

MEMBER BOWNE: That's fine. I would support that. My objection was also as Mr. Zatkin's with the all-payer system. I don't think that's a viable funding source.

MEMBER KARPF: Nancy, what that doesn't do, it doesn't define a funding stream --

MEMBER FARBER: It doesn't establish where -- but it's good enough.

MEMBER KARPF: It defines a

principal --

MEMBER FARBER: It's good enough to get the subject on the table, so that makes me happy.

CHAIRMAN ENTHOVEN: Michael, would you read it once more just so that everybody's -- and then we will -- I'll suggest that without objection we'll accept that as an amendment. But let's make sure everybody's --

DEPUTY DIRECTOR SINGH: And make sure that the court reporter gets it.

CHAIRMAN ENTHOVEN: Yes.

MEMBER KARPF: "The education and

appropriate training of medical providers is a public good. The financial support for medical education has never been clearly defined. To a substantial degree, the cost of medical education has been supported by clinical revenues through cost shifting. As pressure on reimbursement intensifies and clinical revenues are threatened, more discreet funding streams need to be identified. It is in the interest of the public to define the cost of medical education and to develop stable funding mechanisms for the continued excellence of medical education."

CHAIRMAN ENTHOVEN: Do we put that at the end of the Paper?

MEMBER KARPF: Yeah.

CHAIRMAN ENTHOVEN: All right. Without

objection, we'll incorporate that in the Paper.

Now, if someone could move to adopt the Paper.

MEMBER RODRIGUEZ-TRIAS: Move.

CHAIRMAN ENTHOVEN: Donna?

MEMBER CONOM: I just have to keep bringing up one other issue, and that's the research issue. It's almost the same -- almost the same thing. Could you add medical education and research, or would you have to make it different?

MEMBER KARPF: I think that the research issue is a very complex one. I don't even

call it a research issue. I don't think it is the -- research is clearly a public good. When I talk about supporting research -- when I talked about it initially, I didn't mean it in the sense of biomedical research. That's not the responsibility of the state, and that's necessarily the responsibility of payers. But there is a form of research which I think is really clinical verification of efficacy, which I think is quite important. Because one of the things we need to do is define standards of care, define what is meant by medical necessity and have that based on evidence or consensus of appropriate people whenever possible. When you do that, you also define what isn't standard of care. And that

starts getting around some of the questions of whether something is appropriate or not. And there are new modalities that will be evaluated that often diffuse into the public environment before they're proven. And then you have to go back and prove that they don't work.

In the Practice of Medicine Paper, I think Dr. Spurlock has crafted some language that speaks to that issue. And I would rather bring it up there because it really is the practice of medicine and the standard of care issue that I think it should focus around.

MEMBER CONOM: Okay.

CHAIRMAN ENTHOVEN: Okay. I think we --

MEMBER KARPF: (Inaudible) because (inaudible) contribute to that. But others can also.

CHAIRMAN ENTHOVEN: We have a motion.

MEMBER BOWNE: Second.

MS. SINGER: Can I do one quick clarifying? I've just been told that in the second sentence it might be more appropriate to say "financial support for" instead of "medical education health professionals" --

MEMBER KARPF: Health professional education.

MEMBER O'SULLIVAN: I wonder who told

her that.

MEMBER KARPF: I have a feeling we know who it was. We've heard her before.

UNIDENTIFIED SPEAKER: You weren't even here this morning.

MEMBER KARPF: I heard it for a couple of weeks.

(Multiple speakers.)

CHAIRMAN ENTHOVEN: All right. We have a motion. It's been moved and been seconded to adopt the Paper as amended by Dr. Karpf. The findings, yeah. All in favor?

DEPUTY DIRECTOR SINGH: Those opposed,

please raise your right hands.

Twenty-four to zero. The recommendation -- the findings are adopted.

CHAIRMAN ENTHOVEN: All right. We'll next take up physician/patient relationship.

DEPUTY DIRECTOR SINGH: That's 6-D, Physician/Patient Relationship; Findings and Recommendations.

General comments on this, please.

MEMBER GILBERT: You want to just go through the recommendations? There's been some friendly amendments and some potential unfriendly amendments suggested.

So starting with 2-A(1) --

CHAIRMAN ENTHOVEN: Roman Numeral 2 designates the recommendations.

MEMBER GILBERT: I was going to put in some changes that I think clarify.

MEMBER LEE: We did it and voted on each one.

MEMBER GILBERT: Right. I'm just starting with the first one. We're on physician/patient relationship, page 4.

DEPUTY DIRECTOR SINGH: It's Tab 6-D.

(Multiple speakers.)

MEMBER GILBERT: Starting with 1(a). Are we adopting -- we had a suggestion, but it sounds like we're going to adopt routine language

for this. We were going to simply say "the Governor and Legislature should require" and take out "authorize the state agency for managed care regulation." That's change one is remove "authorize the state agency for managed care regulation."

The second change was in that same sentence,"require health plans and medical groups/IPAs to," take out "right contractual arrangements that," and simply say "to enable consumers for undergoing a course of treatment." And then this is a very long run-on sentence. Keep going. We're down to the -- one, two, three, four, fifth -- sixth line. Since we've enabled them, we

don't need to "to be able." So we can dump that. And to continue saying they're current providers not specialty providers because there may, in fact, be -- the primary care physician may, in fact, be providing the care for their chronic disease. So it would now read like this those changes: The Governor and Legislature should require health plans and medical groups/IPAs to enable consumers who are undergoing a course of treatment (chronic, acute or disabling condition)" et cetera, et cetera, et cetera, "for other than cause at the patient's option to continuing seeing their current providers until the course of treatment is completed" et cetera.

CHAIRMAN ENTHOVEN: What about up to a maximum of 90 days or until the patient --

MEMBER GILBERT: That's all included still.

CHAIRMAN ENTHOVEN: Yeah. Okay. Any objections to those changes?

Jeanne?

MEMBER FINBERG: No, I don't object to that. I had an additional comment.

CHAIRMAN ENTHOVEN: Okay. Speak into the microphone, please, so I can hear you.

MEMBER FINBERG: Okay. There was some concern that this language might have

unintentionally narrowed current law. And current standard is what's consistent with good medical practice. So -- and I didn't think that was the intent here. So I thought maybe we could throw in that phrase probably at the end or -- after IPA? Brad's suggesting after IPAs consistent with good medical practice just in case that's broader than this. For example, there might be something important that took 91 days.

MEMBER SPURLOCK: Jeanne, do you think that's different than safely transitioned? Isn't that what that says?

MEMBER FINBERG: Well, because they have this maximum of 90 days, which I would think in almost all cases would take care of it. But

because the standard -- good medical practice isn't limited by days, I just want to be clear that we're not trying to abridged current law.

MEMBER ZATKIN: Actually, Maureen had a suggestion that -- which said you start with the phrase "existing law requires plans to have policies in place allowing for continuity of care when enrollees involuntarily change health plans. The Governor and the Legislature should" -- and then I guess I would say "in addition require." So then it's clear that it's not --

MEMBER FINBERG: Okay. Sure.

MEMBER LEE: Good.

MEMBER FINBERG: In addition to current law, yeah. That would be fine.

CHAIRMAN ENTHOVEN: Steve, would you read that again so we can --

MEMBER ZATKIN: "Existing law requires plans to have policies in place allowing for continuity of care" --

CHAIRMAN ENTHOVEN: Too fast. "Existing law requires" --

MEMBER ZATKIN: " Plans to have policies in place allowing for continuity of care when enrollees involuntarily change health plans. The Governor and the Legislature should in addition" and go on.

MEMBER FINBERG: Thank you.

MEMBER HARTSHORN: I need a clarification.

CHAIRMAN ENTHOVEN: Yes, Terry.

MEMBER HARTSHORN: I was -- I want some clarification. You said for cause.

MEMBER GALLEGOS: Other than cause.

MEMBER HARTSHORN: Other than cause. What happens if a doctor has been terminated for quality reasons or is being --

(Multiple speakers.)

MEMBER HARTSHORN: I have a concern, too, if doctors voluntarily leave. In other words,

when we say "terminate," do we mean it's action by the plan to terminate.

MEMBER GALLEGOS: Yes.

MEMBER HARTSHORN: Because I don't think we should preclude it for doctors if they voluntarily leave.

MEMBER GILBERT: But they have consent because we modified -- we said involuntarily change health plans. We made that voluntary versus involuntary.

MEMBER SPURLOCK: Terry, I think "terminated" means --

MEMBER ZATKIN: Terminated means an action by the plan.

MEMBER SPURLOCK: If they involuntarily leave, are they -- that's not for cause. So that's

incorporated in the language.

MEMBER LEE: Terminated addresses the other side.

MEMBER LEE: No other amendments?

CHAIRMAN ENTHOVEN: Let's just take B at the same time.

MEMBER GILBERT: I have no additions or things that --

MEMBER HIEPLER: There's a couple concerns on this that have been brought to my attention. If you're in a capitated environment, you know, presumably the doctor saw a group of

patients an may only receive a subcapitation if he continues on that time. I think this is something that needs a lot of study as to how you're going to continue to compensate for the one patient that stays in the pool when the rest of them leave because the contract's terminated.

So I propose that this might be struck as -- because we don't know what the payment mechanism is and how to appropriately pay the physician who hangs on to a sick patient so as not to disincentivize them from keeping that one sick patient who wants to stay.

MEMBER SHAPIRO: Mark, can I make a friendly amendment to yours? You have a letter from Senator Share that raises this issue about -- in fact, you don't risk adjust a few patients that

might require the continuing care. So in a capitated environment, this suggestion may not be fair. He only suggests striking "accept the plans rates as payment in full" but leave the rest because it will be quality assurance and other issues and leave to the plans and the physicians dealing with the case-by-case rate issues which -- if it's a case-by-case payment, if fine. But if it's a capitated payment, both sides may agree to renegotiate it.

MEMBER GILBERT: So it would read

"Providers who continue to treat such patients must provide all necessary information to the plan" et cetera, et cetera.

CHAIRMAN ENTHOVEN: Well, there's a problem, then. It's like that the plan has to pay the provider whatever the provider demands. I mean there has to be some --

MEMBER SHAPIRO: No, that's silent. You're simply not dictating a capitated rate for the sickest patient that required continuity of care. You're not taking a position one way or the other if you do that. Let the docs and the HMO work it out.

MEMBER ZATKIN: What happens if they don't agree?

MEMBER SHAPIRO: Well, then the question is do you want to endorse the HMO

capitated rate in all cases even when you failed to use risk adjustment and they're taking the sickest patients.

MEMBER FARBER: It seems like it's fair if they started with it.

MEMBER SPURLOCK: We could put in here -- Mr. Chairman, I'd be very, very worried that if we had no statement in there that actually individual doctors would suffer dramatically in this because they have no bargaining leverage in that individual situation.

I think what we're talking about are the rates for out-of-network-type services. Those are claims-based rates. We're trying to keep that as the floor. I think if we talk about that as floor -- they can negotiate higher if they want to. But I think if we keep an individual doctor at risk for having the leverage to -- leverage is going to be impossible.

CHAIRMAN ENTHOVEN: So you're saying, Bruce -- that would make a lot of sense. Let's accept the plan's out-of-network rates.

MEMBER LEE: Right. For such care.

MEMBER BOWNE: That's better.

(Multiple speakers.)

MEMBER WILLIAMS: One small problem with that, Alain. It just has to do with precise terminology, not the concept. But if you're in an

HMO product where the health plan has an PPO product, then the in-network rate is based on the PPO. The out-of-network rate becomes something different.

I think that -- one thing that I think many health plans do is really, in their existing contracts, contemplate what will happen as part of that so that that's part of the kind of upfront discussion and negotiation.

But I think -- I attempt to be precise

here. I think that the goal is a very good goal. I support the goal. I hear you, Bruce. I certainly think that the individual physician needs to be protected as well as the health plan should be protected against the physician who wants to charge through the growth opportunity.

MEMBER SPURLOCK: So can we say ", or in a PPO environment in the in-network rate"? Could we just add that on simply? Or PPO rate would be fine from where we sit.

MEMBER WILLIAMS: That's the point. I accept that.

CHAIRMAN ENTHOVEN: "Accept the plan's PPO rates as" --

MEMBER SHAPIRO: "Plans out of network or PPO rating."

CHAIRMAN ENTHOVEN: Okay.

MEMBER WILLIAMS: "PPO" --

MEMBER GILBERT: So that providers that continue to treat such patients must accept the plan's out-of-network or PPO rate as payment in full" et cetera.

MEMBER LEE: Et cetera. Right.

MEMBER WILLIAMS: That's fine.

CHAIRMAN ENTHOVEN: That's friendly. Without objection.

All right. So now we have recommendation A(1).

MEMBER LEE: And B, whatever.

CHAIRMAN ENTHOVEN: And B. A and B.

MEMBER LEE: Move adoption.

MEMBER BOWNE: Second.

CHAIRMAN ENTHOVEN: All in favor, please raise your right hand.

DEPUTY DIRECTOR SINGH: Those opposed? Mr. Gallegos, are you opposed? I'm sorry, you raised your hand.

MEMBER GALLEGOS: No, no.

DEPUTY DIRECTOR SINGH: Twenty-six to zero.

MEMBER FINBERG: What was the number?

DEPUTY DIRECTOR SINGH: Twenty-six to zero.

MEMBER FINBERG: Wow.

(Multiple speakers.)

MEMBER GILBERT: No. 2, the authors

have no specific changes.

MEMBER BOWNE: Motion to adopt No. 2.

MEMBER KARPF: Second.

DEPUTY DIRECTOR SINGH: Any discussion?

MEMBER O'SULLIVAN: I want to see if there's -- maybe we could do a quick straw vote to see if there is any openness here to reconsidering something we let go last time, which was that when

a doctor -- or when a provider is terminated or the contract isn't renewed, that patients be notified and that there be a means to challenge the termination for the doc, such as binding arbitration. We had discussion. I just want to see if there's --

MEMBER BOWNE: See if everybody's changed their minds?

MEMBER O'SULLIVAN: Uh-huh. Maybe we got one --

MEMBER BOWNE: I haven't.

MEMBER LEE: Why are we not surprised.

MEMBER GILBERT: Maryann, are you talking about those in addition to No. 1? Like C on No. 1?

MEMBER O'SULLIVAN: I wasn't sure where it belonged, if it belonged under 1 or 2. Maybe it would be better to stay under 1.

CHAIRMAN ENTHOVEN: We have a motion on

the floor to -- and seconded to adopt recommendation 2. Any further discussion?

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation No. 2, please raise your right hand.

MEMBER FINBERG: We're not allowed to comment on 2? I thought we were still talking about 1.

CHAIRMAN ENTHOVEN: No, we're talking

about --

DEPUTY DIRECTOR SINGH: The Chairman asked for discussion on No. 2.

MEMBER FINBERG: I'd like to comment on 2. You know, I basically like recommendation No. 2. But I notice that in order to get this type of standing referral that you need to have the primary care provider, the specialist and the medical director. That's kind of a pretty heavy-duty requirement, a lot of hoops to go through. I wanted to suggest and see if we could eliminate the medical director.

MEMBER GILBERT: I'll object on general grounds.

MEMBER LEE: Can we clarify "elimination"?

MEMBER FINBERG: Let me tell you what I mean because I think that -- you know, currently, if you had a situation that the primary care

doctor, the specialist and the medical director all agree, you're going to get that. That's no problem. We're trying to get something that facilitates something a little more easily.

CHAIRMAN ENTHOVEN: Michael.

MEMBER KARPF: I think this point makes a principle. I think that's the only thing you really can do is make a principle. You can't

micromanage the process, and you can't cut the medical director out of a system between the subspecialist and the primary care doctor. You're going to have chaos in terms of reporting, who's going to get paid; who isn't going to get paid. I think you stick with the principle of individuals have chronic diseases should have their subspecialist as their primary care doctor when appropriate. And let the plans figure out how to do it.

MEMBER FINBERG: So that would be taking out the specifics -- I would be happy to go along with that. I just feel like when you have those specifics in --

MEMBER KARPF: Take out the specific names. It's the principle that counts.

MEMBER FINBERG: Okay.

DEPUTY DIRECTOR SINGH: Dr. Karpf, are you --

CHAIRMAN ENTHOVEN: Are you agreed

to --

DEPUTY DIRECTOR SINGH: We have to -- actually -- because you have a motion on the floor, at this point, I'm sorry, you need to make a motion to amend this recommendation to delete "medical director." It needs to be seconded, and we have to vote on that.

MEMBER GILBERT: Hang on. We're not

just deleting "medical director."

(Multiple speakers.)

MEMBER KARPF: You leave all three in or you take all three out.

DEPUTY DIRECTOR SINGH: In any event, you need a motion to do that.

MEMBER GILBERT: We'll do that in a second. Why don't we come up with the language, and then we can do the Parliamentary procedures. Is that acceptable? If we could just come up with the language.

DEPUTY DIRECTOR SINGH: That's fine.

MEMBER BOWNE: Wait a minute. Since I made the amendment, would you accept it as a friendly amendment? Then it just says "prolonged or permanent referral to a specialist when appropriate." Is that what you're saying? And leave out all the three parties.

MEMBER KARPF: Yeah.

MEMBER LEE: That's good.

MEMBER RODRIGUEZ-TRIAS: Uh-huh.

VICE-CHAIRMAN KERR: I second that.

DEPUTY DIRECTOR SINGH: All right. So at this point we're going to vote on the amendment.

MEMBER SPURLOCK: I have a comment.

MEMBER BOWNE: Well, actually, since I

made it, I was taking it as friendly. We don't have to vote.

DEPUTY DIRECTOR SINGH: So without objection, we'll take it out.

MEMBER SPURLOCK: Yes, I object. I'm sorry. The words "when appropriate" just drives a wide hole so any train can go through there. And the concept that I tried to do at the last meeting a Saturday ago was that we don't want to blow up the primary care process. We want the primary care doctor to be in the loop. And the referral has to be at the physician level -- the specialist to the primary care doctor and the rest of it.

So I think if we take out all of them, we lose that. We lose about who's going to decide what's appropriate and what the appropriate mechanism is. I think we need to be very specific and deal with the first amendment which is just the medical director and deal with that issue because that's what, I think, Jeanne was getting at initially. I think when you broaden the rest of

it, you have the risk of blowing up the primary care process, which is a coordination and integration role for the entire system.

MEMBER O'SULLIVAN: Why don't we see if we have votes for taking out just "medical director."

CHAIRMAN ENTHOVEN: But Michael has

explained why --

MEMBER KARPF: I will yield to Bruce's judgment. Do you think that that decision can be made without the agreement of a medical director in a plan?

MEMBER GILBERT: From a process point of view, Bruce, it would be very difficult.

MEMBER SPURLOCK: I wouldn't want to speak for the medical director.

MEMBER LEE: Can I make a potential --

MEMBER KARPF: We do have a medical direction on this panel. Could we hear from the medical director?

MEMBER LEE: I think that the intent of Jeanne's amendment is not to eliminate the medical director, but it's the note that the decision could be made with the primary care and the specialist, but they would still need to consult with the medical director. The medical director couldn't trump the decision.

So couldn't we reword it to note that if

the primary care provider and specialist determine and then, comma, in consultation with the medical director? But the question is who's doing the determining. We are trying to cut the medical director out of the loop. But if there's a disagreement, they can make that agreement.

Is that, Jeanne, your intent? Would that be friendly.

MEMBER FINBERG: Yes, so far as I understand it.

MEMBER FARBER: I think you guys are getting right down into the middle of how the health plan does their job. Some health plans may have a rule that says that the primary care division leader in consultation with a specialist could do this by themselves; another one may say anything you do like this has to be done by a medical director. I strongly encourage you to go back to the principle as stated by Dr. Karpf and leave it at that. You can't tell a health plan to manage their medical groups or medical groups how to manage themselves.

MEMBER KARPF: Can I reword it and say that physicians with chronic conditions should be allowed to have their subspecialists -- patients with chronic conditions -- there are a lot of physicians with chronic conditions. Patients with chronic or life-threatening conditions should be

capable of having their subspecialist provide -- their subspecialist essentially provide all of their primary care or focus all of their care?

MEMBER SPURLOCK: That was the language we had last time. If we want to go back to what we had before we came up with -- we had a straw vote

that went in this direction.

I think the notion is we don't want to get rid of the primary care process. That needs to be in there for integration, coordination. That person needs to be a part of the decision-making process with the specialist. The only question now is how much involvement does the medical director have to have? I'm not a medical director, but we can hear how that process needs to make out.

MEMBER GILBERT: Because, remember, there may be many other decisions that have to be made in relationship to this patient. There may be diagnostic testing that has to be approved. There may be many other facets to their care that's not specifically related to the care by the specialist. If the medical director's not a part of that, they're not going to be able to make the right decisions for the other care that could be needed, including additional specialty providers, additional diagnostic testing, et cetera.

MEMBER WILLIAMS: I guess I would argue that the --

CHAIRMAN ENTHOVEN: Okay. Ron.

MEMBER WILLIAMS: I would argue that the sentence as stands is a good sentence. That the directional intent of what we're saying is clear. That we cannot sit here and contemplate all

of the clinical decisions that a medical director who may need to make -- and some health plans a medical director wouldn't be involved; in others they would need to be involved. It's one basic question that is a specialist credentialed by the health plan. Health plan's going to be held accountable for the quality of care that's ultimately delivered in this situation.

So it seems to me we have to focus on the principle -- be clear on the principle and not try and micro wordsmith.

CHAIRMAN ENTHOVEN: I'd like us to vote on this now. We've really -- just on the motion before us --

MEMBER GRIFFITHS: I was actually going to try to suggest another alternative that might help. People are concerned about having the medical director. Why not simply -- because there will be different plans that run in different ways. Why not simply require the plan to have some process by which the primary care provider consults with a specialist pursuant to whatever process the plan, you know, develops. They, you know, come up

with a decision on whether to do this or not. Some medical directors have oversight for hundreds of doctors. I question whether they have the ability or the time to be involved in every one of these cases.

CHAIRMAN ENTHOVEN: Well, they would delegate in that case, wouldn't they?

MEMBER GRIFFITHS: Is that clear that they could --

CHAIRMAN ENTHOVEN: Yeah.

MEMBER GILBERT: Diana, would the intent be to create a process with the result of the process being that there is an extended referral for specialty care?

MEMBER GRIFFITHS: Right. Exactly.

MEMBER GILBERT: We could use language that simply says the health plan is required to have a process that defines how members with chronic disabling, et cetera, conditions are able to get extended or prolonged referrals for specialty care.

MEMBER GRIFFITHS: That's the concept.

MEMBER LEE: That sort of takes us to the when appropriate. We can do a period after of "specialist."

(Multiple speakers.)

MEMBER FINBERG: Yeah, I'm happy with that.

MEMBER LEE: It's not saying either "when appropriate" nor the other language we had earlier.

DEPUTY DIRECTOR SINGH: Is there a

motion to make that amendment, Members?

MEMBER FINBERG: Yeah. I so move.

DEPUTY DIRECTOR SINGH: Was there a second?

(Multiple speakers.)

MEMBER GILBERT: After "specialist" would be a period. All the rest of that particular sentence would be deleted.

CHAIRMAN ENTHOVEN: Right.

DEPUTY DIRECTOR SINGH: Any further discussion on the amendment?

MEMBER DECKER: Which specialist?

MEMBER GRIFFITHS: Which specialist?

MEMBER LEE: "Or permanent referral to a specialist," period.

DEPUTY DIRECTOR SINGH: And then strike "if any and the plan medical director"?

MEMBER RODRIGUEZ-TRIAS: And starting with "such referrals."

MEMBER GILBERT: Then the last sentence would stay, "such referrals should be conducted."

DEPUTY DIRECTOR SINGH: Those in favor of the amendment, please raise your right hand.

Those opposed?

The amendment is adopted, 24 to 0.

Is there any further discussion on Recommendation No. 2 before we vote on that.

MEMBER LEE: Move adoption.

DEPUTY DIRECTOR SINGH: Those in favor of adopting recommendation A(2)?

Those opposed? Twenty-seven to zero. That recommendation is adopted.

MEMBER GILBERT: Okay. No. 3. No. 3. Some slight wordsmithing. "If a patient is specifically assigned to or chooses the primary care provider and the provider, provider's medical group/IPA or health plan directs that patient to another physician, advanced practitioner, physician's assistant, the patient should be informed verbally and should consent prior to the appointment."

MEMBER FARBER: Say that again.

MEMBER GILBERT: "If a patient is specifically assigned to" -- so adding the word t-o -- "or chooses a primary care provider, and the provider, provider's medical group/IPA or health plan directs that patient to another physician, advanced practitioner or physician's assistant, the patient should be informed verbally and should consent prior to the appointment."

MEMBER SCHLAEGEL: "Appointment" or "assignment"?

MEMBER FARBER: Prior to the assignment.

MEMBER GILBERT: Well, no. Actually,

the assignment is still to the person that they chose, but then they're being directed elsewhere for that particular visit or that appointment.

MEMBER KARPF: What happens if the doctor's on vacation or gets sick? Does that mean you need...

MEMBER DECKER: You have to cancel all appointments. You don't get to sub.

MEMBER LEE: She's kidding. She's kidding.

MEMBER FINBERG: Then you say "Hi. Dr. Smith's on vacation. Is it okay if I see you?"

MEMBER KARPF: Then the patient says --

MEMBER FINBERG: Of course, I'm not a doctor.

MEMBER KARPF: Change "assignment" for long-term relationship is one thing; substituting on an incidental situation is something else.

MEMBER ALPERT: Which ones?

MEMBER KARPF: Or if someone comes in in an emergency and says "I want to see my doctor. My doctor's in the hospital" --

CHAIRMAN ENTHOVEN: What's the real point of this thing anyway?

MEMBER GILBERT: The point of this

thing is that there are practices where individuals choose a specific provider, and then they are directed to a different provider for a variety of

reasons: That physician was really full and really -- isn't able to take on new loads of patients. They're directed to a different level of a provider because there may be cost savings related to that. So the intent was if someone is making a specific choice to see a given provider, they should see that given provider unless --

CHAIRMAN ENTHOVEN: Okay. But what if the given provider -- I mean I want to go to the most favorite doctor in the clinic, but they tell me her practice is full. I can't go --

MEMBER GILBERT: You've already been assigned under this scenario.

MEMBER RODGERS: I think the issue was if you're assigned to a physician, the person expects to see that physician. They get to the clinic, they see somebody else; that is a dissatisfier. This just says before you make that appointment with an alternative doctor, they need to be told that you're not going to see Dr. X; you're going to see Dr. Y.

MEMBER DECKER: I think there is a shift here. Maybe my memory is getting fogged. But I thought when we discussed this before, it really was talking about on a per-appointment

basis. But what was just said makes it sound like I've selected a PCP, and now there's a game going

on to try and shift the economic realities in that practice. So I agree with Dr. Karpf when he said it earlier. I thought this was all on a per-appointment basis. Now we're talking about a more like strategy that we're trying to prevent. So can we clarify what we're dealing with?

MEMBER LEE: If I could suggest something. That was certainly the intent. I think that unclear language is "directs," and I think that it directs for an appointment that they be sent to another physician. The intent is on the appointment basis.

If you call up and think I'm going to see my doctor, you're going to be told otherwise and told they aren't available or whatever and get your consent: "Okay. I'll come in anyway." It doesn't -- this would never be interpreted -- we're getting in that language to say if a doctor's sick and you show up that day, you tell them they're sick. But we aren't saying that. There's no, as someone say, a bate and switch. If you think you've got a PCP and you get in every time and you get an RN, an RN may be great and may be appropriate. But you're told that phone. But you aren't going to get that without being informed ahead of time.

So that directs for an appointment that patient. Would that be a friendly amendment to

clarify we're talking about an appointment level?

MEMBER GILBERT: Yes, that was the intent.

MEMBER FARBER: Okay.

CHAIRMAN ENTHOVEN: Okay. Did we have a motion to --

MEMBER HARTSHORN: I have a question about how can we -- how can health plans, I guess, determine that these types of communications are going on, you know, between the doctor and the patient? I mean isn't that -- that's pretty far down the line for some of the health plans. I'm wondering if -- I don't if this is appropriate, but that goes on in lots of settings not just in health plans. It can go on in a physician's office that is seeing a PPO patient, a fee-for-service patient. And is this right to just try to it stick it in something that's involving health plans when it's a consumer issue that affects all of us.

So my question is: Should that be under the Medical Practices Act not under here? So -- because it impacts everybody. I think it should.

CHAIRMAN ENTHOVEN: Okay. Tony.

MEMBER RODGERS: I think the language where you're specifically assigned to a physician or have specifically chosen a physician is what is

the operative language here. We are trying to

assure that the consumers -- because the product is a physician, if you will, that they -- it's an OB/GYN or it's an internist, et cetera, and then the next thing they get is a PA when they come to the office and they're not told that they're going to have a PA. That's the issue that keeps coming up as a dissatisfier that we're trying to resolve.

As a health plan, if we change the physician, we have to communicate that to the member. At the doctor's office, I think it should be part of their normal practice to let the member know if the physician's not available or they're going to be assigned to a different practitioner.

So I think it's a reasonable thing to do for the consumers. And I think --

MEMBER HARTSHORN: I would agree. I'm not arguing that it's not reasonable. I'm saying it probably impacts more than just the health plans and physicians here.

MEMBER ZATKIN: Terry, it's not directed -- I mean it's written so it may -- it could apply directly to providers as well as the plans. And it's not written to say the regulatory agency shall require the plan.

MEMBER LEE: This will be subject to our --

MEMBER ZATKIN: It's an open question

about how it would -- or to whom it would apply.

CHAIRMAN ENTHOVEN: Okay. Is there --

MEMBER FARBER: I'd like to make a motion to be approved as an amendment.

CHAIRMAN ENTHOVEN: Thank you. Second?

UNIDENTIFIED SPEAKER: Second. Rt Thank you.

MEMBER SPURLOCK: Could we have the reading.

CHAIRMAN ENTHOVEN: What?

MEMBER SPURLOCK: Could we read what we're approving?

CHAIRMAN ENTHOVEN: "If a patient is specifically assigned to or chooses a primary care provider, and the provider's medical group/IPA or health plan --

MEMBER FINBERG: "The provider, providers" -- rt "Provider," --

MEMBER FARBER: "Provider's medical" --

(Multiple speakers.)

CHAIRMAN ENTHOVEN: "And the provider's"?

(Multiple speakers.)

CHAIRMAN ENTHOVEN: "Provider's medical group/IPA or health plan directs that patient for an appointment to another physician, advanced practice nurse or physician's assistant, the

patient should be informed verbally and should consent prior to the appointment."

All in favor, right hand.

DEPUTY DIRECTOR SINGH: Those opposed?

Twenty-five to zero. The recommendation is adopted.

CHAIRMAN ENTHOVEN: This is incredible.

MEMBER LEE: I take it back. Let's do Regulatory Organizations now.

(Multiple speakers.)

MEMBER GILBERT: No. 4. No. 4. No author's changes to No. 4.

CHAIRMAN ENTHOVEN: Okay. No. 4.

MEMBER GILBERT: No author's changes.

CHAIRMAN ENTHOVEN: Brad, when I read this, I made my note beside it "meaning unclear." You may have to -- if I can't understand it -- maybe I'm the only one.

MEMBER GILBERT: I think this was Bruce's -- Bruce, where are you? This is the idea that all levels in the care process, information is available to the patient regarding their experience and qualifications. And we've changed this many times. I believe that Dr. Spurlock is responsible for this particular --

MEMBER SPURLOCK: I'll rise to that challenge.

MEMBER GILBERT: Thank you. Since you've eliminated medical directors. I'm gonna...

MEMBER SPURLOCK: It wasn't me. It wasn't me.

I think the goal here was to improve the informed consent process and to improve the informed consent process with data. And we wanted to make sure that it was good data; that it wasn't just self-report data. It wasn't just "I've done this many procedures, and I'm good," because I think that's questionable. I think the whole idea was that we were going to try to improve the informed consent process all along. So it wasn't just at the time when you're going to get the knife, but would actually happen early on in the process. So a procedural approach to a informed consent. That was our attempt.

Now, if we have language to try to accomplish that that's more clear or explains better, I'm all ears.

MEMBER HARTSHORN: I don't know if I've got language that can clarify. Because I support this in principle. Again, now we're bringing in the hospitals, which, again, has to be brought in. But why are we only pointing to those regulated by -- in managed care? In other words, it should happen --

MEMBER SPURLOCK: We aren't --

MEMBER HARTSHORN: -- to everybody. Again, is it under the Medical Practices Act where it fits better?

MEMBER LEE: It could be. This isn't limited by that at all.

MEMBER HARTSHORN: But the way this report comes out, it will be something just for the managed care industry, where it should be interpreted -- if it's for consumers, it should be for everybody.

MEMBER LEE: Can I make a suggestion back to the Executive Summary is that by definition, many of our recommendations touch upon all aspects of health care provisions whether, quote/unquote, managed or unmanaged. Many of the consumer information people, I absolutely agree, have to cut across all hospitals or, you know -- so I think that would be a worthwhile introductory statement that I think we'd all agree with. Is that --

MEMBER HARTSHORN: It's underlying --

MEMBER LEE: Underlying goal.

MEMBER HARTSHORN: I'll be happy.

MEMBER LEE: I was noting that many of the recommendations we make do touch upon non-managed care. And whether we're talking about a hospital may or may not have managed care contracts. The intent is to have this data

available at the hospital level. That's an introductory mark in the Executive Summary to say that our recommendations are -- cut across the health care delivery system.

CHAIRMAN ENTHOVEN: Uh-huh.

MEMBER LEE: I have sort of a technical cleanup here that I think there's -- may not address the other issues is that the first sentence really, I think, fits better in the paragraph above, which is -- the paragraph above is sort of an introduction to this recommendation that says "other parts of our report make recommendations about care and process, outcome measures being reflected and disseminated." And I just suggest moving that up so this recommendation starts with "As information becomes available," et cetera. Is that -- and we haven't moved anything yet. Is that acceptable to the author?

MEMBER GILBERT: Certainly.

DEPUTY DIRECTOR SINGH: Is there any objection?

MEMBER SPURLOCK: Sort of a cleanup "As quality information," instead of just saying "as information" -- sort of what kind of information.

MEMBER GRIFFITHS: That's my question, too. What kind of information are we talking about?

VICE-CHAIRMAN KERR: Quality

information.

MEMBER GRIFFITHS: Do you have some modifier?

CHAIRMAN ENTHOVEN: "Quality-related information"? "Information relevant to the quality of care"?

MEMBER FARBER: Yeah.

MEMBER FINBERG: Then you probably want to add the Consumer Information and Involvement Paper also.

MEMBER LEE: It is up above, but it's not below. It puts those two Papers together, then.

MEMBER FINBERG: Okay.

MEMBER LEE: The (inaudible) consumer information and quality information are both in the introductory paragraph.

MEMBER FINBERG: Okay. I got it.

CHAIRMAN ENTHOVEN: Ms. Decker.

MEMBER DECKER: I just noticed, because Peter was directing our attention towards it, there's a mention of the Streamlining Paper in the introduction. I don't think that exists any longer.

MEMBER LEE: Cut "streamline" out.

CHAIRMAN ENTHOVEN: In the Government Organization Paper.

Okay. So what we've got, then, is that

the first sentence would go up into the previous paragraph, and 4 would become "As information relevant to the quality of care becomes available, physicians, regardless of financing or delivery system, should include all relevant information at every level of care in the informed consent process." "To the extent information is known, accurate or reliable, a physician in hospital should make available upon request all relevant information regarding their experience and/or qualifications regarding a course of care patients are considering."

MEMBER LEE: Moved.

MEMBER WILLIAMS: Is there someplace in there affordability for all of this? I mean I can see people putting out wheelbarrows --

UNIDENTIFIED SPEAKER: All relevant information. Does that include the person's whole background --

MEMBER GRIFFITHS: Could we just say "relevant information"?

VICE-CHAIRMAN KERR: It says that. It's all relevant information.

CHAIRMAN ENTHOVEN: Oh, take the "all" out? I mean it just gets to be pretty --

MEMBER SPURLOCK: Any relevant information.

DEPUTY DIRECTOR SINGH: Is there

objection to take out -- there's a motion on the table to --

CHAIRMAN ENTHOVEN: Take out "all" in both cases?

MEMBER LEE: I hadn't made the motion. No one seconded my motion.

DEPUTY DIRECTOR SINGH: That's right.

MEMBER LEE: So I would say fine, pull out the second "all" and make the motion. And someone can second it then.

DEPUTY DIRECTOR SINGH: We need the second.

MEMBER HIEPLER: I'll second.

CHAIRMAN ENTHOVEN: All in favor?

DEPUTY DIRECTOR SINGH: All in favor of adopting recommendation 4 as technically amended, please raise your right hand.

MEMBER NORTHWAY: What's the last sentence? Oh, well.

DEPUTY DIRECTOR SINGH: Is it clear?

MEMBER LEE: "Should make available upon request relevant information regarding."

DEPUTY DIRECTOR SINGH: Those in favor, please raise your right hand.

MEMBER NORTHWAY: I'm going to raise my left hand. I'm not quite sure.

EXECUTIVE DIRECTOR ROMERO: You're cancelling yourself out.

DEPUTY DIRECTOR SINGH: Those opposed?
The recommendation is adopted 25 to 0.
CHAIRMAN ENTHOVEN: Recommendation 5.
MEMBER GILBERT: This one you've got to bear with me. There was a fair amount of input to this one. And then we have another one that's related to it.
The Governor and the Legislature should monitor federal reforms related to confidentiality of patient information and patient access and rights with respect to their medical records." So we're inserting after "patient information and patient access and rights with respect to their medical records and ensure that state law is consistent. In addition, the Governor and Legislators should review state law to ensure confidentiality of individually identified health care information and patient access and rights with respect to their medical records" --
UNIDENTIFIED SPEAKER: Where are you?
(Multiple speakers.)
MEMBER LEE: I think what he's doing is inserting additional language to lead in the file.
(Multiple speakers.)
MEMBER GILBERT: I'm sorry. This is --
(Multiple speakers.)
DEPUTY DIRECTOR SINGH: Members, we're on recommendation No. 5 at this point.

MEMBER FARBER: He took a hard right. We don't know where he went.

MEMBER ZATKIN: We're linking it to the federal process.

MEMBER GILBERT: This is a substitute for 5.

DEPUTY DIRECTOR SINGH: Dr. Gilbert, just for clarification purposes, it's my understanding that you're going to delete the previously written Recommendation 5 and substitute it with the recommendation that you're reading.

MEMBER GILBERT: Now that I know that, yes.

MEMBER LEE: This seems like a relatively long one that we might all agree with, but it's sort hard so we'll just write it in. Can we table this one recommendation and maybe get copies of this made so we can all look at it?

MEMBER GILBERT: We'll redo it, because I've got it in pencil.

MEMBER LEE: And then come back to this one rather than try to do us writing the long thing down.

DEPUTY DIRECTOR SINGH: Is there objection to defer the voting on this recommendation until a little bit later this afternoon when it can be -- without objection.

CHAIRMAN ENTHOVEN: There's no

objection.

MEMBER GILBERT: There's one more issue. It's very short, but significant. One of the Task Force Members reiterated that there was discussion around the issue of signing releases. So there's been a suggestion in this section -- in the Patient Confidentiality section. And if you want, we can write this up and include it as an additional -- like it would be a B. "No health plan or any of its contractors should be allowed to require an enrollee as a condition for securing health care services to sign a release or consent form which waives any medical information, confidentiality protection authorized by law."

MEMBER LEE: That sounds great.

CHAIRMAN ENTHOVEN: Make that a 5-B.

MEMBER GILBERT: Make that 5-B, and we'll bring the whole thing back.

CHAIRMAN ENTHOVEN: All right. We've completed, with the exceptions of 5-A and B.

DEPUTY DIRECTOR SINGH: Just, again, for clarification purposes, Members will also vote on the entire document once we've voted on the new Recommendation No. 5 as well. There will be two votes that we'll need to make.

MEMBER HAUCK: Why don't we vote on everything that was just approved, and let's deal with that.

CHAIRMAN ENTHOVEN: That's a good idea. All right. We'll just vote on approving the whole Paper --

DEPUTY DIRECTOR SINGH: The Findings and recommendation section, as we've been doing.

MEMBER LEE: I have -- we're going to do Findings?

CHAIRMAN ENTHOVEN: No.

MEMBER LEE: No? Never mind then.

CHAIRMAN ENTHOVEN: We're going to approve everything up to 5.

MEMBER LEE: Well, if it is Findings, I have one very small amendment I'd like to request to Findings, which is on page 4, the paragraph that says Recommendations, Roman Numeral 2, after good old Cardinal Bernardine is to insert ", and the relationship between patients and other health professionals." I would think that's a friendly amendment. I am inserting at the end of this long sentence, "Cardinal Bernardine period, comma, and the relationship between patients and other health professionals."

CHAIRMAN ENTHOVEN: "Practicing within the legally authorized" --

MEMBER LEE: I don't think we need that there.

CHAIRMAN ENTHOVEN: Also "guiding principles PLE."

UNIDENTIFIED SPEAKER: I have a question. This morning we received some testimony that changed under E, Physician Availability. I think it's three sentences from the bottom where it starts "to reduce costs, managed care organizations" --

MEMBER HAUCK: Page 3.

UNIDENTIFIED SPEAKER: I'm sorry, page 3. This Section E in the Findings.

MEMBER FINBERG: Thank you.

MEMBER LEE: There was suggested amended language to that that I suggest we adopt.

MEMBER O'SULLIVAN: We all have it. It's the letter that the nurses put in front of us.

CHAIRMAN ENTHOVEN: Strike "to reduce costs"?

MEMBER SCHLAEGEL: No, there was --

MEMBER LEE: Does someone have it so they can read that? Maryann, could you read the language that's suggested?

MEMBER O'SULLIVAN: Yeah. The language that would be added is "many matters" -- actually, you all have it, if you want to look at it. The American Nurses Association.

MEMBER LEE: But it would be interesting to read it into the record.

MEMBER O'SULLIVAN: "Many managed care

organizations use advanced practice nurses and physician's assistants to provide preventive, primary and secondary care and reserve physicians' time to care for patients with complex disease processes. All patient visits have a medical and emotional impact on patients. Consumers report that advanced practice nurses and physician's assistants often communicate more clearly than physicians who are more limited by time constraints." I didn't do it, and I'm laughing.

MEMBER ZATKIN: You might want to --

(Multiple speakers.)

MEMBER LEE: Particularly when they talk to medical directors.

MEMBER O'SULLIVAN: How about if we propose the first two sentences there? That would mean deleting -- the proposal from the nurses was also to delete the -- basically the sentence that says the reason you use these kinds of practitioners is to reduce costs.

DEPUTY DIRECTOR SINGH: Without objection, we'll accept that. At this point, Members, could we have a motion to adopt the Findings and Recommendations except for E.

MEMBER LEE: Move adoption of Findings.

DEPUTY DIRECTOR SINGH: Is there a second?

MEMBER NORTHWAY: Hang on a second.

DEPUTY DIRECTOR SINGH: I said except for 5 -- E or 5.

MEMBER NORTHWAY: I'm not totally sure what we just accepted without the Recommendations.

MEMBER FARBER: Without a vote, yeah. What just happened?

CHAIRMAN ENTHOVEN: All right.

DEPUTY DIRECTOR SINGH: It was without objection. If we want --

MEMBER BOWNE: They're objecting.

(Multiple speakers.)

MEMBER LEE: They're not objecting; there's a question.

MEMBER NORTHWAY: I just want to know what I'm not supposed to object to. Could you read again --

MEMBER O'SULLIVAN: I read three sentences. This time I'll just read two sentences.

MEMBER NORTHWAY: Slowly.

MEMBER O'SULLIVAN: You have it in front of you. It's the nurses' letter.

MEMBER NORTHWAY: I've got a lot in front of me.

MEMBER O'SULLIVAN: I know. "Many managed care organizations use advanced practice nurses and physician's assistants to provide preventive, primary and secondary care and reserve

physician time to care for patients with complex disease processes. All patient visits have a

medical and emotional impact on patients."

That sentence was designed to replace the one that says that the physician visits -- that was it.

MEMBER FINBERG: What are you taking out? The sentence that says to reduce cost --

MEMBER O'SULLIVAN: The cost.

MEMBER FINBERG: Just that one sentence or more?

MEMBER O'SULLIVAN: Actually, two sentences. The sentence that began -- no, three sentences. It's negotiable.

CHAIRMAN ENTHOVEN: I was a little surprised by primary --

(Multiple speakers.)

CHAIRMAN ENTHOVEN: Usually you think of secondary care as being referral care between primary care doctors?

MEMBER FARBER: Yeah.

CHAIRMAN ENTHOVEN: You're doing secondary care with --

MEMBER FARBER: You're right. You're fine.

CHAIRMAN ENTHOVEN: Yeah. Yeah. Right. I agree.

MEMBER NORTHWAY: What's coming out?

MEMBER O'SULLIVAN: Propose taking out the sentence that begins "To reduce costs." The

next sentence --

DEPUTY DIRECTOR SINGH: We're taking that sentence out, "To reduce cost"?

MEMBER O'SULLIVAN: Yes.

CHAIRMAN ENTHOVEN: And also the next one.

MEMBER O'SULLIVAN: We could take out those three sentences.

MEMBER FINBERG: So starting with "To reduce costs" and ending with the word "impact" is all deleted.

CHAIRMAN ENTHOVEN: Yeah. And then we keep the other one, "shorter visits that may be medically acceptable can still be a source of patient dissatisfaction." We replace those with these new words.

MEMBER FARBER: Well, could you read the new words?

CHAIRMAN ENTHOVEN: Yes. "Many managed care organizations use advanced practice nurses and physician's assistants to provide preventive, primary and secondary care and reserve physicians' time to care for patients with complex disease processes. All patient visits have a medical and emotional impact on patients and carry on shorter

visits that may be medically acceptable can still be a source of patient dissatisfaction."

DEPUTY DIRECTOR SINGH: Is there any

objection to that technical amendment?

MEMBER NORTHWAY: No objection. I just -- what's a shorter visit? I mean I don't understand that last sentence. What does that mean.

CHAIRMAN ENTHOVEN: Well --

MEMBER NORTHWAY: Just because you're there for five minutes, you can still make somebody mad?

CHAIRMAN ENTHOVEN: That's a variable that enters into patient satisfaction.

MEMBER NORTHWAY: How does that -- okay.

DEPUTY DIRECTOR SINGH: Seeing no objection, we'll accept that amendment. And at this point, it has been moved and seconded to adopt the Findings and Recommendations omitting recommendation No. 5. Those in favor, please raise your right hand.

Those opposed?

Twenty-three to one. The findings and Recommendations are adopted except for No. 5.

MEMBER SEVERONI: There were two.

DEPUTY DIRECTOR SINGH: I'm sorry. I stand corrected. Twenty-three to two. I didn't

see the second one.

CHAIRMAN ENTHOVEN: Okay. Come on, Class. I think we deserve a short break. But

first, I am contemplating that now I believe we have 27 people here; that it's enough to do Government; right? Without objection then, we'll take on Government next. All right. Fine. Without objection.

(Brief recess.)

CHAIRMAN ENTHOVEN: Members, please take your seats. I trust your kind indulgence here that you're having to put up with comings and goings and so forth. I've decided to go back to what we previously said, and we'll put Regulatory Organization on first thing in the morning tomorrow. One of my admirers on the Legislative appointee side pointed out, unbeknownst to me -- my information was that Allan Zaremberg was not here and wasn't going to be here, and that he was walking in as I was saying that. It looks as if I waited until Zaremberg walked in to make that decision. There is more --

Pete, you're going to be here tomorrow morning?

UNIDENTIFIED SPEAKER: Wait a minute.

CHAIRMAN ENTHOVEN: There's more going on than that. I have other reasons that I just

prefer to -- trust me.

MEMBER FARBER: I'd like to know what the reasons are.

CHAIRMAN ENTHOVEN: We're doing a

little behind-the-scenes work here to see if we can find some way to deal with this. So we're going to go on with Choice. All right.

MEMBER HAUCK: Does that person want me to leave, Alain?

CHAIRMAN ENTHOVEN: No. Expanding Consumer Choice.

MEMBER BOWNE: What tab?

MEMBER LEE: 5-A.

CHAIRMAN ENTHOVEN: That's Agenda Item 5-A. We'll have to pull this.

First, just to deal with kind of a hardship case here, I agreed that we'll hear briefly from Mr. John M. Curtis, Discobolus Consulting Services, who is going to speak for three minutes or less on the Regulatory Paper. And then he can fly back off into the fog.

MR. CURTIS: Chairman Enthoven, Dr. Romero, Ms. Singh, Task Force Members, distinguished guests, California stands at the threshold of one of America's biggest challenges: Finding a cure for a disabled health care system which no longer serves the need of its people. Today's managed health care system is no longer

acceptable. It's sick, and it needs our help.

As usual, California, with over 10 percent of the population of this nation, must lead the way. Washington's eyes are fixed on this Task

Force to provide a blueprint for the future. Our nation's health truly depends on our work. Our goal is not to do away with managed care but to make it more responsive. Let's fix the system, not eliminate it. Providers must also be considered in this equation because they are the ones delivering the services.

The challenge before us is to find a solution which increases the quality and responsiveness of all managed health care services. All groups involved including patients, doctors, health plans, allied professionals must share the burden equally, but they will also share in the bounty of an improved health care system for our citizens. All must be committed to building a better managed health care system.

Because of the rapid proliferation of managed health care plans, it now constitutes over 90 percent of the health plans sold in California and more than 75 percent nationwide. The industry clearly needs its own independent department for oversite and regulation. And yet today's HMOs are different. Only Kaiser Permanente remains

California's last vertically integrated health system. All other HMOs contract out for their medical and hospital services.

One of the most consistent consumer complaints against HMOs or managed health care

systems is denial of access to plan benefits. This constitutes the most serious abuse, since a plan without access to benefits is like having no plan at all.

To this end, any oversite department must take up the issue of what percentage of premium dollars must be spent by HMOs on actual utilization of plan benefits.

Currently, the DOI regulates the claims/loss ratio and various insurance products such as disability plans. In this way, consumers are assured that a reasonable percentage of premium dollars go toward paying out actual benefits.

Under HMOs' current capitation arrangements, no such control is in place. Today, the amount of premium dollars collected for health plans is not monitored for how much is actually paid out in medical cost. What's known is only the capitation rates paid by HMOs to contracted IPAs and hospitals. Many IPAs and hospitals have complained that the competition has driven capitation rates so low that they can't afford to deliver medical services to plan subscribers.

Because of this, many IPAs and hospitals are forced to either ration medical services or face extinction.

In the face of Medicare, the Health Care Financing Administration, HCFA, presently pays HMOs

about $5,000 a year to manage the complete and total care of its beneficiaries. HMOs typically pays its IPAs in the neighborhood of 1,200 to $1,500 for a given patient; a whopping 400 percent profit. At 100 to $125 a month, IPAs easily run in the red and pray that the aggregate dollars collected will pay their overhead. Is it any wonder that many HMO enrollees complain that they're being denied access to needed medical benefits. For the IPA, rationing medical benefits is a matter of fiscal survival.

Establishing an office of health care regulation oversite is the first and most important step in correcting the current HMO system which squarely places all financial risk on IPAs. The forgotten relationship between today's HMOs and their contracted IPAs who provide all the medical care services must be studied and monitored closely. These are truly the dangerous seams in the current system.

Health plans must once again accept the financial risk of doing business. Placing the

financial risk on physicians punishes them for --

CHAIRMAN ENTHOVEN: Thank you, Mr. Curtis. Can you just wrap it up, please.

MR. CURTIS: Placing -- one more sentence.

Placing the financial risk on physicians

them for practicing responsible medicine. Clearly, the current managed care system as we know it today is crying out for some help.

Thank you.

CHAIRMAN ENTHOVEN: Thank you, Mr. Curtis.

Please turn to Item 5-A.

DEPUTY DIRECTOR SINGH: Expanding Consumer Choice.

CHAIRMAN ENTHOVEN: Okay. We'll go right to the discussion of the Recommendations. This is -- oh, my god. Mine doesn't have page numbers.

DEPUTY DIRECTOR SINGH: I think mine doesn't either.

MEMBER LEE: It's not just you, Alain. Don't worry.

CHAIRMAN ENTHOVEN: So on page 4 -- well, the first recommendation is pretty innocuous. It's just an attempt to say --

MEMBER LEE: Move adoption.

CHAIRMAN ENTHOVEN: -- everyone favors

choice.

UNIDENTIFIED SPEAKER: Second.

MEMBER BOWNE: All those in favor.

DEPUTY DIRECTOR SINGH: Recommendation No. 1 as proposed. Please raise your right hand.

MEMBER FARBER: Wait a minute.

DEPUTY DIRECTOR SINGH: Actually, Members, I'm sorry, we didn't ask for the discussion. Is there any discussion on recommendation No. 1? Okay. Please raise your hand if you're in support of adopting of recommendation A.

Those opposed?

The vote is 24 to 0. Recommendation No. 1 is adopted as proposed.

CHAIRMAN ENTHOVEN: Okay. The second is recommending that the state make it a public -- matter of public policy to facilitate and encourage the development of purchasing groups.

MEMBER LEE: Move adoption.

MEMBER BOWNE: Second.

CHAIRMAN ENTHOVEN: Discussion?

All those in favor, please raise your right hand.

DEPUTY DIRECTOR SINGH: Those opposed?

The vote is 23 to 0. The recommendation is adopted.

CHAIRMAN ENTHOVEN: The third one. I'd just like to note that in discussion afterwards, the general intent of raising the threshold for the small group of laws to 100 was to make it possible for the HIPC to operate up to that level in the hope that the HIPC would be able to Expand its enrollment by doing that. So this is not a

noncontroversial -- I guess first we -- since the -- conforming the HIPC is a new idea that we haven't seen, we have to kind of straw vote that in or out and then take up the recommendation.

Ron, would you --

MEMBER WILLIAMS: I guess I'd like to speak on the whole recommendation. I don't know what the best sequence is to do this, Alain.

CHAIRMAN ENTHOVEN: Well, could we just first deal with the question of the conforming suggestion.

MEMBER BOWNE: But, Alain, if we don't -- I think that it's all tied together. I don't think it's acceptable.

CHAIRMAN ENTHOVEN: Then we'll have to deal with the whole thing. I mean should the package include that or not. I think it's probably a detail that --

MEMBER RAMEY: I don't think the conforming suggestion makes any difference because the HIPC goes wherever the small group market

goes. So if the small group market's 2 to 100, that's where the HIPC will be.

CHAIRMAN ENTHOVEN: It's not in the statute that the HIPC stops at 100?

MEMBER RAMEY: It's that the purchasing entity like the HIPC cannot operate outside of a reformed market. It's very difficult to do medical

underwriting and variable pricing in the HIPC-type environment. So, therefore, it can't exist outside of that market.

CHAIRMAN ENTHOVEN: I see.

MEMBER BOWNE: They're not separable.

CHAIRMAN ENTHOVEN: Yeah.

MEMBER RAMEY: They're not separable, right.

CHAIRMAN ENTHOVEN: You're saying this is just not necessary because you can assure us that -- all right. Well, in that case, let's just take it out. I'm striking the conforming suggestion on the firm advice of John Ramey, who is the world's leading authority on this, the founding father of the HIPC.

DEPUTY DIRECTOR SINGH: Without objection?

CHAIRMAN ENTHOVEN: That it goes without saying. All right. So now let's have discussion on the No. 3.

Okay. Ron Brown?

Rebecca, did you say --

Oh, God, I'm sorry. I'm sorry, Ron. I've got a circus in my head. I apologize. I did it before and I kicked my myself all the way home. Please forgive me.

MEMBER WILLIAMS: Forgiven.

CHAIRMAN ENTHOVEN: Ron Williams.

MEMBER WILLIAMS: I think that this is one of those proposals that is, I think, very well intended in terms of the desire. I think, however, again, the concept of counter-intended consequences is likely to be what the outcome turns out to be. That we will end up pushing employers into self-insurance. We will end up with a market between 51 and 100 where there is less choice when we finish than there was when we started. And I go back to while I think the state HIPC has been very successful in many dimensions, one of the dimensions is that there is not a lot of choice between the HMO and the PPO product in that category.

I think also for very rapidly growing multi-state company's who need lots of choice, who need extremely rich benefits to be able to compete in a high technology, a very competitive market, forcing standard benefits, which is what you end up with in a small group environment and a limited

number of choices because you have all these affirmative disclosure laws -- what we're going to end up with is taking a market segment that is working very, very well today and end up reducing choice, end up pushing people into self-insurance, end up reducing the number of PPO options that these -- both employers and employees have as a result of this recommendation.

I have yet to see personally any compelling case that there is a need for this level of draconian change in a market that seems to be working very well.

CHAIRMAN ENTHOVEN: Rebecca Bowne and then after that Kim Belshe.

MEMBER BOWNE: We had considerable discussion about this before, and obviously there are a number of different opinions on this among the Task Force. This has also been a considerable issue of national debate.

Prior to the passage of the Health Insurance Affordability and Accountability law of last year, 1996 -- that's a federal law -- there were variations in small group size among all the states. Some had 1 to 25; some had 1 to 50; some had 2 to 25; some had 2 to 50, kind of a variation. And some of the states had proposed at one time going up to 100 or not.

When the federal law was passed, there was a national standard set for small groups to be established at 2 to 50. There certainly are those who would advocate including groups of 1, and there are those who would advocate including larger groups.

If we were to adopt this amendment, California would be running counter to what is happening nationally, what has only recently been

passed. And while I do think that this clearly was done with good intentions for broadening the market, what happens -- and I can speak to you as a PPO plan, not an HMO plan -- in the HIPC, I believe that -- if I'm not mistaken, there's only one PPO left; is that correct?

MEMBER RAMEY: None, I think.

MEMBER BOWNE: None. None left. And I would suggest to you if you put this through to expand it up to 100, what you will be doing for employers of 51 to 100 employees is only permitting them the choice of HMOs. And in fairness, I know that both Kaiser and Pacific Care support this expansion. And I would have to say to you, I think it is a move to help eliminate a variety of other providers in the market who now are serving this market and serving it fairly well. It's not perfect. There are glitches. But I would suggest that your good intentions would very much go awry

to expand without considerable depth and study about this. And this was done at the federal level, and it was done in a number of state levels. And I would urge you not to adopt this particular amendment.

CHAIRMAN ENTHOVEN: Could we just clarify? Are you sure, John, that PPO is totally dead within the HIPC now?

MEMBER RAMEY: No.

MS. BELSHE: We have PPOs, but very limited PPO choice remains.

MEMBER RAMEY: Right.

MS. BELSHE: We have EPO. But Rebecca's general point is valid. There's very, very limited PPO choice remaining.

CHAIRMAN ENTHOVEN: Then what's going to happen is the small -- or the 50 to 100 employers who feel they need to have wide access will simply go to non-regulated self-insured PPOs.

MS. BELSHE: That's one of the concerns that there is.

MEMBER BOWNE: Yes, that's correct. Because, see, what happens in a small group market is that any carrier must guarantee issue any product that they have in the market. In other words, if a small group comes to you, you can't say "No, I don't want to offer you the plan."

You must offer the plan, and you must do it within the rate constraints that have been sent out by the state.

Now, this was passed for good reason. Because if a small group has an individual who either they or a family member or they have a track record or, you know, maybe they have some disease that's expensive or retardation or something, you want to be able to spread risk more broadly in the small group and have certain kinds of rate

constraints.

But at this point in time, we do not have evidence that that needs to be expanded on out from the 51 to 100 market.

CHAIRMAN ENTHOVEN: Next is Kim Belshe.

MS. BELSHE: Thank you, Mr. Chairman.

Just to associate my comments with those of the last two speakers, this is an issue where we have spent a lot of time in the administration, with the Legislature exploring the extent to which there is a problem in the size group market and what strategies -- what viable strategies are available to us in terms of expanding choice to the extent that it's a problem.

The write-up itself acknowledges that there is not a clear consensus; that there is a problem as it relates to meaningful coverage options in the mid-sized market.

I'm also struck by the fact that while the comments -- one sentence has indicated in terms of what the supporters feel on this issue, what the opponents say is footnoted and is far more detailed in terms of laying out some fairly compelling concerns associated with this proposal, concerns which we have just heard from the previous two speakers.

But as Ron indicated in his comments, the intent is a laudable one. The concern is a real

one, though, the extent to which there are unintended consequences associated with this policy.

We have been trying for years in California to get some specific information as to the extent of the problem in terms of choice in the mid-sized market. There have been interested parties who have said in the past that they were interested in sponsoring a survey to get a better idea. The extent to which this is a problem, that has never been conducted and completed.

To the extent there is a lack of consensus represented in this Task Force, a lack of consensus that would be consistent with the statement of this Paper and consistent with the broader universe of interested parties, perhaps the Task Force might want to consider a recommendation,

much like it has in a number of other areas, to study this problem and to make it clear that this is an area where we need to invest some time and resources to ascertain what coverage options are available to the mid-sized market with an eye towards developing recommendations for expanding choice if, in fact, it is deemed to be considered to inadequate, including expanding small groups to conform to 100 and a discussion of what implications are associated with those options.

But it strikes me -- the background

findings does not substantiate the recommendation that's made.

CHAIRMAN ENTHOVEN: Kim, I think that you're saying the opponents are in a footnote -- it happened in the back and forth of -- you know, I think it's reasonable that we should put that back up in the text. I mean it wasn't a deliberate plot.

MS. BELSHE: I understand. I made it -- just in terms of presentation, it's a little awkward to put it in a footnote. But beyond that, the more substantive point is there are some fairly significant issues associated with this recommendation.

CHAIRMAN ENTHOVEN: Okay. Michael Shapiro, and then Steve Zatkin.

Michael, did you have your hand up?

MEMBER SHAPIRO: Yes, I did.

CHAIRMAN ENTHOVEN: Okay. Calling on you for a brief comment.

MEMBER SHAPIRO: Thank you.

CHAIRMAN ENTHOVEN: We have read your materials.

MEMBER SHAPIRO: Good. What I was going to suggest is that the experts in the room on this are John Ramey and Richard Figeroa who staffed out this recommendation. I take exception to the idea that the opposing argument's in a footnote.

This recommendation was not in the original Paper. We provided supporting arguments which were not put in the Paper and are sparse in the appeals part of the Paper. Not because there aren't supporting arguments -- and we actually did a cut and paste -- but because staff and those who tried to (inaudible) incorporating those arguments in the Paper, but maintain the opposing arguments at length in the footnote. So in terms of the Paper fairly describing the pros and cons that we discussed earlier, it still does not. And I agree with Kim Belshe it doesn't. And that's a reflection of how the Paper was handled earlier.

This is not -- I oppose the idea of a study. I'd rather we have an up or down vote. If it doesn't pass, it doesn't pass. This has been

before the Legislature for a year. These two Bills -- the Brulty (phonetic) Bill and the Rosenthal Bill -- have gone through the entire process with support from the small business community that has indicated they have trouble getting access and choice for their employees. And that selecting out risks is what's happening in this mid-sized market. So the repeated argument that there is no support by the small business community for this is just not supported by the record that we maintained earlier, and that we argued should be reflected fairly in this Paper.

Now, we indicated that this is not without controversy, which is why we receded on the individual market performance that said this is the one where you can manage the risk of mitigating against self-insurance and mitigating against market reform and driving out options. And those arguments have been made. I would, again, defer to John Ramey and, to the extent possible, Richard Figeroa to make those arguments. But we indicated those were manageable. The former Paper that I circulated had those arguments, which are not reflected in this Paper still. And I won't belabor it, but I think if this group is about market reform and choice, this is really the only choice mandate being proposed by this body. And if you want to reform the market and give people

choices, and the driving force in California is the mid-sized markets, that's where the employees are, 51 to 100.

CHAIRMAN ENTHOVEN: Okay. Thank you. Steve Zatkin.

MEMBER ZATKIN: Yeah. I just want to respond to a point that was made earlier regarding the question of why we support this. And it is not for the purpose of driving PPOs out of the market at all. It is because we think that the guarantee issue in the group market is the right thing to do.

At a previous meeting on this, I suggested that if the rate limits under the small group area were too tight for the circumstances, that we ought to look at flexibility there. And I would repeat that as a possible recommendation.

But we have supported market reform for a long time, and we will continue to do so. And it is for the reason I stated.

CHAIRMAN ENTHOVEN: Thank you. Diane Griffiths.

MEMBER GRIFFITHS: Thank you. I was wishing that I talked with Les before we got here. I wanted to recount a conversation I had regarding Milstein about a month ago.

UNIDENTIFIED SPEAKER: Could you pull

the microphone...

MEMBER GRIFFITHS: I wanted to recount a conversation I had with Arnie Milstein with the PGH about a month ago on this exact issue. And starting with -- there are two issues: One is is there a problem in the market; and the second issue is what to do about it. Let me start with the first.

We talked about that. As Kim points out, we've had lots of discussion over the years about whether there's a problem in this market or not. So I was obviously interested in what his opinion on that subject might be. And he didn't hesitate

for a moment to represent that he perceived there to be a problem in the market. I have to confess that I didn't go through all the various (inaudible) of AB1672, which was the original Market Reform Bill. But we did talk about the HIPC in particular and about the advisability of adding those size employers to the HIPC. He indicated to me that he thought that would be very beneficial to that market. So I -- you know, I found that to be credible evidence.

As well, perhaps I should indicate that I start with a kind of jaded perspective about what could happen to the market if we do these things. Because having worked on the original Legislation back in, I think, '92, there were all kinds of

horror stories about what that -- what that reform will would do to the market. And, in fact, in almost all respects, it's been universally beneficial to employers.

So I don't see this as an area where promoting a lot of hysteria has necessarily borne itself out with the experience (inaudible) in 1972.

CHAIRMAN ENTHOVEN: Thank you.

Allan Zaremberg.

MEMBER ZAREMBERG: I'd like to ask a couple of questions.

Dianne -- and I agree there was a lot of concern. And one of the concerns when 1672 was

debated, I believe, was that there would be a loss of PPO options to small employers. And I think it was felt that it was worth the trade-off because it was difficult to get affordable health insurance. And wouldn't you agree that has been a consequence?

MEMBER RAMEY: I would like to that, Mr. Chairman. The answer to that is I don't think so. Although it's been a problem in the HIPC in that the HIPC only represents at the most 2 percent of that market -- 2 to 3 percent of the whole market. And there are some excellent PPO options in the market available generally. Blue Cross has -- you know, agressively markets their PPO in

the small group market as does Blue Shield and several other companies -- and since the 1672 reforms.

MEMBER ZAREMBERG: I'm kind of curious because Allan said one of the purposes here -- and what your purpose is -- was to have this in the -- to do this to expand HIPC.

CHAIRMAN ENTHOVEN: And the number of people who have multiple choice of plans is the underlying idea.

MEMBER RAMEY: Well, I think that that would help. I think expanding the reforms would help the number of people having multiple choice of plans because the 1672 market reform environment

has been one in which there has been more competition amongst plans to offer their services at lower rates. And so there has been more availability in the marketplace since the reforms nad not less. But I think that it's important to note that the HIPC is another presence in the marketplace. It's by no means dominant in the market. It offers an option for employers and employees in the marketplace. But you're -- if you -- you don't want to frame this discussion in terms of the HIPC. Because if you did, you would be framing it in terms of 3 percent of the market as opposed to 97 percent of the market.

In my mind, the reason for doing this is

that I think we all want to have an environment in which everyone that can possibly purchase health insurance is able to do so without restriction at the most affordable price and certainly not be penalizied excessive in terms of their -- of the health history of the group that they represent.

There is an expense to that, because there are some groups that come into this market, particularly when you get to the smaller groups and they come in and out mostly motivated by the health condition which they're experiencing at the moment. And that does represent an expense to the marketplace. But by limiting that to below the 50 groups, you're saddling those employers with the

entire burden of that privilege that we want to extend to the marketplace. And it would be a much fairer more competitive and I believe a healthier market if it was expanded to 100 employees because I think below that threshold there is very little self-insurance really that goes on in that environment. And as a result of that condition, it's a favorable thing to do.

MEMBER ZAREMBERG: Well, a couple things.

Kim, is it true that the HIPC didn't offer the Access Plus Blue Shield Plan because it wasn't standardized enough? I was just trying to

get an idea of point-of-service plans in the HIPC.

MS. BELSHE: We do offer efforts -- I mean among the choices, offer our point-of-service plan. The Access Plus was not offered because it was viewed as a significant departure from the standards.

MEMBER DECKER: It's an HMO.

MEMBER ZAREMBERG: That's what I'm saying. I'm just trying to get a couple points. And Ron and, I think, Rebecca can answer a question because I -- what I'm concerned about here is that we have a Paper dealing with consumer choice. And I think Ron's point is the consequences to limit consumer choice. And I think whether Les or Barbara, has anybody suggested that we change ERISA

to reduce the amount of PPOs who are offered by their employers or the people in PPGH, that they would be very concerned that their employees not have the opportunity or their employers to use fetalized PPOs.

And I think the goal here is to expand the options of available to the employers and their employees. And John has said -- and this is where I'm very confused -- that he thinks there is a very -- that the PPO market hasn't suffered from the guarantee issue and (inaudible) of the 50 market. And since Rebecca and Ron have spoken against this, I'm confused about that. And my

concern would be that we have a market in the 50 to 100 where you have choice, choice between HMOs; Access Plus, which is an HMO with a point of service that's -- can't -- isn't even offered by the HIPC; and secondly -- and thirdly, PPOs. And I would want to make sure if our goal here is to expand choice, that we don't do something that limits choice. And because of those reasons -- and I understand it -- we have opposed that -- we have 11,000 members statewide; 80 percent of which are fewer than 100 employees and very concerned about that option. And like I said, I can't imagine any large employer would want the same things to happen to them. Maybe Ron or Rebecca could answer those questions.

MEMBER WILLIAMS: Yeah. Just a couple comments. I think from where I sit it is accurate to say that there are fewer PPOs operating in California today. And by name, American Health, John Aldrin, Principle, Humana has also talked about leaving the market, and Wausau. And those are companies that were active in the PPO market who are not active today.

I think also the concept of expanding choice is a definition in which in our desire to give those members in an HMO a choice of multiple HMO options, we deprive them of the ability to

select a PPO. And I think that's the concern.

I think giving them multiple options of an HMO is a desirable objective. I think experience has shown that there were several PPOs who had been in and out of the HIPC, and the risk dynamic simply weren't able to work successfully yet.

The other thing which I think is very important is to compare a firm with 10 or 15 employees with a firm of 80 or 90 employees. Those are dramatically different organizations. They have dramatically different employee relation issues; they're often multi-state; they're competing in an environment which often benefits and one of the things that they have to match because often recruiting people from much larger

organizations. They have to offer the kind of benefits that they would get at Bank of America or at any other large employer.

So I think in answering your comments, Allan, we're going to limit choice of PPO plans. There are demonstrated examples of PPOs that have left the state. We're going to end up with less and less choice.

From our own parochial point of view, we think it's great. But we don't think it's good for the industry as a whole and for the consumer as a whole.

CHAIRMAN ENTHOVEN: Griffiths.

MEMBER GRIFFITHS: I just have one quick additional comment.

I wanted to remind the Members of the Task Force something that came up when we discussed this Paper last, which is that the Small Business Association does support this proposal. I know Allan has members of his organization that are small business people. But he has small and large business people on his board, and the Small Business Association does support the expansion.

MEMBER ZAREMBERG: Is that the group that supports an employer mandate?

MEMBER GRIFFITHS: I don't know.

MEMBER BOWNE: Yes. Yes, it is.

MEMBER ZAREMBERG: You literally need a

small business (inaudible).

MEMBER WILLIAMS: Yeah, they do support, as I recall, an employer mandate.

MEMBER ZAREMBERG: My experience with my members is overwhelmingly opposed -- members of both large and small (inaudible).

CHAIRMAN ENTHOVEN: Ron, I understood the way that the HIPC was working is, first, that they really desire to be attractive to small employers who would like their employees to have a choice that includes a PPO. And that's one of the

reasons that they've led the way in risk adjustment, and that the risk adjustment was intended to -- and I thought had kept the PPO viable because always the wide-access products are likely to --

MEMBER WILLIAMS: I'm certainly willing to be corrected on this point factually if I am wrong. But I looked the HIPC enrollment data through November yesterday. And I think it's fair to say that it has been a struggle, and there has been a decline in the PPO enrollment. The PPO enrollment is extremely marginal. I'm not sure who is the PPO that is being offered; is it a statewide plan.

MS. BELSHE: Blue Shield, I believe.

MEMBER RAMEY: It's Blue Shield, but it's not offered statewide.

MS. BELSHE: It's not offered statewide.

MEMBER RAMEY: It's offered in the rural communities where there are not many HMO options.

MS. BELSHE: I mean that's a very important point. Choice within the HIPC has declined dramatically since the beginning of the program as it relates to the PPO option. We have struggled to -- from a plan perspective, to have that be a viable participant in the HIPC for a

variety of reasons. Now, whether or not you can assign responsibility --

CHAIRMAN ENTHOVEN: Risk adjustment didn't save it?

MS. BELSHE: I think it's helped considerably. But it has still been a challenge for the Board retain PPO participation in the program.

CHAIRMAN ENTHOVEN: Okay. Diane.

MEMBER GRIFFITHS: I believe I heard John say, though, that PPOs are available in the small market, just that it's declined (inaudible). So there may be other PPO options --

MEMBER BOWNE: But, Diane, I think you were also hearing Ron read off the names of companies who have left the state who were small group carriers and had left offering plans in

California because it's not viable for them to compete here against the HMOs. They can't economically compete without attracting the disproportionate share under guarantee issue. So you would expand that problem also up to the 51 to 100 market.

CHAIRMAN ENTHOVEN: Okay. I think we've had a very good, thorough discussion here. And I think we need to vote.

Kim.

MS. BELSHE: I just want to make a final comment, Mr. Chairman, that one of the barriers -- and Diane touched on this before -- in terms of the Legislative Administration moving forward on this issue in the past, in my mind, has been inadequate information regarding the extent to which there is a problem of access to and choice of affordable insurance in a small group market. We've heard from Diane and Michael that there are additional -- there's additional information, additional arguments to be made to demonstrate that there is a problem.

My final point would be the Paper would be well served to include that information. Because the way the Paper is written right now, it does not make the case, in my mind. It gives very short shrift to the information to demonstrate that there is a problem, and that this solution is

consistent with that problem as defined.

CHAIRMAN ENTHOVEN: All right. Is there a motion?

DEPUTY DIRECTOR SINGH: To adopt Recommendation No. 3.

MEMBER FINBERG: I move.

DEPUTY DIRECTOR SINGH: Is there a second?

MEMBER GRIFFITHS: I'll second.

DEPUTY DIRECTOR SINGH: Is there a

second?

MEMBER FARBER: What are we voting on? No. 3?

DEPUTY DIRECTOR SINGH: Recommendation No. 3. It's been moved and seconded to adopt Recommendation 3. Any further discussion? All those --

UNIDENTIFIED SPEAKER: Just before we vote, Richard Figueroa is here, who has worked in the Legislature on this for years. I wonder if -- Richard, if there's any --

CHAIRMAN ENTHOVEN: I think we're ready to vote. I think we've heard it.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation 3, please raise your right hand.

Those opposed, please raise your right hand.

The recommendation is adopted 17 to 7.

CHAIRMAN ENTHOVEN: Next we have -- let's see -- Clark Kerr's proposal, which was sent to you in a memo December 2nd. We would call this C-4. May I read it, or does everyone have it?

DEPUTY DIRECTOR SINGH: Mr. Chairman, I believe you should read it for the record so the public...

CHAIRMAN ENTHOVEN: Okay.

VICE-CHAIRMAN KERR: I would also like to add a friendly amendment to it.

(Multiple speakers.)

VICE-CHAIRMAN KERR: The background on this was, of course, the idea of trying to have a little bit of out-of-box thinking in terms of trying to expand consumer choice. And the real goal was really to try and help improve and increase consumer choice. And I would like to read this -- you all have your copies. I'd like to read the two friendly amendments to it. It now reads "The Legislature and Governor should convene a working group of stakeholders including health plans, providers, purchasers and consumers to examine the issue of" -- and here's the part -- "how to increase consumer choice of providers, including consideration of a consumer opt-out provision" -- another friendly amendment -- "on a cost-neutral basis, i.e., a patient could get some

coverage for care outside the plan's network under specified circumstances, such as a lift-threatening condition."

The goal of asking for a study was we've obviously seen lots of people who have been concerned about the issue of choice. We have nearly a quarter of the people in California who do not have a choice. They either take the plan or they don't have health insurance. We thought that

at least the issue should be studied, that the pros and cons should be looked at, that we should also look at the what the real cost implications are; is it really possible to get a cost-neutral type of situation. Some people said it is. I think there has to be a step.

So basically the idea is really twofold: It gives people a consumer opt-out situation -- excuse my voice here. You'd think that managed care could finally find the solution to postnasal drip forever. So it gives employees a safety valve and consumers a safety valve to opt out in very specific and extreme situations, such as a life-threatening issue. It also, I think, does something very important. It helps stimulate competition among the health plans to make sure we have quality providers in their networks so that people will not want to do this -- will not need to do this. And it gives them -- it doesn't say

you're locked in and you have no choice. It says you're locked in. And the plans will, therefore, I think, want to have the very best. That calls for a certified, excellent outcome for providers or, as Joan Trotter talks about, the providers of excellence in their network so people will not desire to do this. The details have not been worked out, but, of course, it would be a fairly

substantial co-pay and deductible on the part of the consumers. It would not be something easy to do, but it would at least give them an option, and it would also, I think, help the competition very sincerely in the area of improved quality of networks.

DEPUTY DIRECTOR SINGH: Is that a motion to recommend this amendment, Mr. Kerr?

MEMBER LEE: Before you make it as a motion, could we hear if people have other amendments to it so we don't get locked into our Roberts Rules.

DEPUTY DIRECTOR SINGH: Ms. Farber.

MEMBER FARBER: I have a question about the consumer opt-out provision and your intention with respect to that. The way I understand is that if the consumer was unhappy with where they were being sent within the plan, that they could take that payment that otherwise would have applied to the service within the plan and apply it to a

service outside the plan? Is that what you mean?

VICE-CHAIRMAN KERR: It would not be a point-of-service type of thing for every type. It would be limited to specific areas, which we're giving one suggestion of, say, in a life-threatening type of situation.

MEMBER FARBER: That is --

VICE-CHAIRMAN KERR: So if you had a

stubbed toe, it would not apply.

MEMBER FARBER: No. But say you were going to have brain surgery or something like that. Is that what you mean by this?

VICE-CHAIRMAN KERR: We have not specified exactly, you know, what the payment would be on the outside. What we're saying is that there would be an unspecified deductible the consumer would have to pay as well as a co-pay up to some sort of max -- this is where the study really has to identify how that works -- to try and get as much as possible a cost-neutral basis. That it would then -- the payment to whoever they went to, there's any number of ways that could be. It could be paid on the Medicare rate. We have not specified what that would be.

MEMBER FARBER: Okay. I just was trying to figure out how this would work.

DEPUTY DIRECTOR SINGH: Dr. Spurlock and then Dr. Karpf.

MEMBER SPURLOCK: Thank you. This is an interesting idea. And in general, I'm pretty much in support of looking at studies and work groups. But if you go back to the grid that was passed out to us today, we actually have 15 working groups and convening groups that we're bringing together, and this would be number 16. And in the

grand scheme of things, there's a limit to the amount of work groups that we can convene.

I don't think this is an idea that's not worth -- I think it's worth an investigation, but I'm not sure it's necessarily the role of the government to convene this group. It's an innovative idea and an idea that expands choice. I think it would be very popular amongst folks in other areas. I actually think that we need to allow this to happen in the private sector to come out first. I think there would be some deleterious effects that it's politicized from the government's role. And I agree with the bracketed statement in line C that says "Some Task Force Members may want to continue to explore options for expanding access to providers." I think that's a better solution than asking the Government to convene this group as the sixteenth group that we could look at. That will probably politicize the process, and that may kill it in the long run.

VICE-CHAIRMAN KERR: It's always

possible that copies can be provided and several groups look at several topics.

DEPUTY DIRECTOR SINGH: Dr. Karpf.

MEMBER KARPF: Yeah, I agree. If we have too many groups, then we'll need to prioritize among the issues. And when we get down to the issue of access, this is really central to many of

the complaints we have heard. What this kind of option does do, it does provide a safety valve for individuals who are unhappy. It also does hold them accountable. It isn't done in a capricious or lackadaisical manner. If people want to opt out, then we'll have to invest in that.

I have -- because I was interested in the issue and because I was concerned as to whether it could be done in a financially neutral way, did, by myself, ask Perin & Towers to do a small actuarial analysis to see if it would have tremendous impact on the cost of care. And, in fact, I have some data that I would share if people wanted that says that one could develop options so it wouldn't, in fact, impact the cost of care in a substantive kind of way.

CHAIRMAN ENTHOVEN: You mean it wouldn't impact premiums?

MEMBER KARPF: Wouldn't impact premiums in a substantive kind of way.

MEMBER DECKER: And who was the source?

MEMBER KARPF: Perin & Towers. I have the data with me if you want me to distribute it.

CHAIRMAN ENTHOVEN: One of the worrisome things is that to make that work, the deductible would have to be so high --

MEMBER KARPF: About 3,000.

CHAIRMAN ENTHOVEN: Three thousand dollars. But then I could just hear Maryann saying "But that's not giving people a choice at all because they don't have $3,000 in the bank to" -- so that's almost not a solution.

VICE-CHAIRMAN KERR: Is that the deductible or the total out of pocket?

MEMBER KARPF: That's out of pocket.

CHAIRMAN ENTHOVEN: Oh, sorry. Total out of pocket. That's a little different.

MEMBER KARPF: Actually, let me distribute the data since I have it with, because I thought it would be an issue that would come up. I happened to make some copies.

VICE-CHAIRMAN KERR: No wonder your plane --

MEMBER KARPF: What?

VICE-CHAIRMAN KERR: No wonder your plane was late.

DEPUTY DIRECTOR SINGH: Mr. Zatkin.

MEMBER ZATKIN: While we're waiting to see Dr. Karpf's data, I'm --

MEMBER KARPF: I would not call this data. This is a quick-and-dirty analysis to see if it's feasible. If it wasn't feasible, I wouldn't support the concept.

MEMBER ZATKIN: I'm sure that one can construct the point of service which does all kinds

of things including getting close to cost neutral. Although, the closer you get to cost neutral, the higher the cost share. And I guess that point of service is out in the market. So what I hear being proposed here is a proposal that would require all plans to include this. Is that correct? This is not -- or are we simply saying this is one option that people ought to be able to get --

VICE-CHAIRMAN KERR: That's correct.

MEMBER ZATKIN: -- among others? It's the latter.

VICE-CHAIRMAN KERR: No.

MEMBER ZATKIN: It's all plans?

VICE-CHAIRMAN KERR: All plans.

MEMBER KARPF: All plans. We're looking for the feasible of that.

MEMBER ZATKIN: If we're saying it's all plans, that means that the opportunity or the right of people to buy and people to construct a plan that provides services to its delivery system would no longer be available. Is that correct?

MEMBER KARPF: No. That doesn't say

that. It says that if an individual is dissatisfied with your plan to the point that they wanted to put up money to get out of the plan, they would have the option to do that. It means that your plan would be held that much -- your plan,

Steve, would be held that much more -- your plan's feet would be held that much more to the fire to keep your consumers happy.

MEMBER ZATKIN: Okay. So currently if people are dissatisfied with the plan, they have a right to disenroll. It's called disenrollment for cause.

MEMBER KARPF: That's true. But once they have had a significant diagnosis and they have cancer, that's not the time that they're going to disenroll and somebody else is going to pick them up because there is a predetermined -- a preexisting condition clause that they can't move with.

MEMBER BOWNE: Excuse me, but no. That's been ruled out by federal law. And as long as someone has continuous coverage, there is no preexisting condition imposed.

VICE-CHAIRMAN KERR: But there are about a quarter of the people in California or more who do not have a choice of plans.

MEMBER ZATKIN: But if the issue -- Clark, if the issue is choice of plan, then we

ought to be supporting giving people a choice of plan rather than saying all plans have to have an opt-out feature which means that no one can sell an HMO product. I happen to think this violates the Federal HMO Act -- that's my personal view --

because the federal HMO Act when it was first established was established to encourage the availability of HMOs.

And included in the Act was a provision which was intended to prevent against state policy, which was designed to eliminate the ability of people to buy and people to sell HMOs. And there is a provision in the Act that says that if the state passes a law that prevents an HMO from operating as an HMO, the law is preempted. There's a reason for that. Congress put it in so that people wouldn't eliminate the ability of people to sell and people to buy HMO coverage, which I believe this does. I think it is in that sense anti-choice.

Millions of people have opted to buy HMOs, five million of our members. And I think if people want to have a point-of-service option, they should be able to get it, and we should encourage that as an option. And I don't think we should say that the only -- that there can be no HMO option. And that's what I see being proposed.

CHAIRMAN ENTHOVEN: Peter.

MEMBER LEE: Having suggested one of the technical amendments made here that I thought would amend it to not be a mandatory provision, what the language that was inserted into what we

were reading is examine how to increase consumer choice of provider including looking at this particular thing. One of the things that I -- why I also suggested that language is we talked about earlier that we don't talk about choice of provider almost anywhere in this Task Force report. This whole section started out being consumer choice, and it became health plan choice. And to have someplace we're saying the issue the consumers need a choice of provider needs to be looked at, and then as a tag-on, here's one of the issues that is being looked at.

But I think that language is that we're trying to focus on consumers need a choice at a number of levels. And this is to suggest there should be a working group to look at that issue. That's what I -- that was certainly my intent with added language --

VICE-CHAIRMAN KERR: This is a recommendation for a working group, right.

MEMBER LEE: And looking at -- the thing they're looking at is increasing consumer choice of providers with this additional language including to look at the language as discussed

previously. I think it's very important that we just --

MEMBER ZATKIN: I don't disagree with the policy which encourages people having options

that give them choice of providers. But that's not --

MEMBER BOWNE: That's not what this says.

MEMBER ZATKIN: That's not what this says. If it did say that, I would support it. If it said that people should have an option available to them which gives them the choice of provider, I would support that.

VICE-CHAIRMAN KERR: Well, the amendment does say increase -- how to increase consumer choice of provider including consideration of the consumer opt-out. In other words, they were just looking at a variety of issues including the consumer opt-out issue.

MEMBER ZATKIN: I have no problem with consumer opt-out.

CHAIRMAN ENTHOVEN: Nancy Farber.

MEMBER FARBER: That's okay.

CHAIRMAN ENTHOVEN: Phil Romero.

EXECUTIVE DIRECTOR ROMERO: Thank you. I can only stay out of the discussion of substance, but I just want to weigh in here with a personal view, and that is that as an economist, I

tend to hate monopolies unless there's no alternative. So I have always personally seen Task Force recommendations on choice as one of a real

crown jewel.

And I've been disappointed that we have run into so many walls -- ERISA and others -- that have so constrained us. And I have been hearing about this consumer opt-out option for a couple of weeks. And I have felt that there were many details to be worked out. And, therefore, I would have been very uncomfortable if the Task Force made a substantive recommendation about a particular product design. But this doesn't do that. You know, this, in essence, hands this off to another group to consider it as well as a number of other options.

And I personally am in favor of this, not because I have a strong brief for this particular product, but because I believe there are choice recommendations because the constraints are quite limited. And I'd like to do as much as we can.

CHAIRMAN ENTHOVEN: Ron Williams.

MEMBER WILLIAMS: Yes. I have really a question and then a comment. Could you explain the difference between this and a PPO product.

VICE-CHAIRMAN KERR: I think in this one -- again, it's (inaudible) to discuss it. In a PPO product you can go outside the network anytime

you want for any reason if you want to pay. The difference that this would be is there would be a much more limited type of situation, such as in the

case where we gave the example of a life-threatening type of situation.

So I think it's a difference of severity. It's really an opt-out safety value in extreme circumstances for PPOs -- if you have a stubbed toe and you want to go somewhere else. It's not the same situation.

MEMBER WILLIAMS: But I think in good practice, it really accomplishes the same thing. I think in terms of my comments -- there really are a couple of comments. I think studying choice is a good idea. I am supportive of the overall direction of it. But it seems to me that what we're trying to do is recreate the PPO option within the HMO. And there are a couple of things I think we just need to be sensitive to as we encourage people to develop products that require fundamentally different skill sets.

One of those is information systems so these turn out to be required information systems that many of the health plans won't have and would need to develop.

The others are fundamental skill sets around actuarial pricing activity. And I think the trick in this is to explore the intent of the

objective and look at how we can create choice and avoid a mandate that places an entity in a business

that might not have the core competency to operate (inaudible).

VICE-CHAIRMAN KERR: We are talking about a working group to study that.

CHAIRMAN ENTHOVEN: I was just studying the Towers, Perin, UCLA, data.

MEMBER BOWNE: Would you speak into the microphone.

CHAIRMAN ENTHOVEN: Excuse me. Take your own medicine, Mr. Chairman. (Inaudible.)

Reading the Towers, Perin data, what I see here is that the zero premium increase product has to have a $5,000 out-of-pocket max. And I presume that does not include coverage of balance billing. That is, that these numbers are going to be based on a fee schedule. And if the particular providers see this patient as a fee-for-service patient, they will be able to charge them a lot more. So that the 5,000 --

VICE-CHAIRMAN KERR: (Inaudible) felt that legislation could be worked around that.

CHAIRMAN ENTHOVEN: Okay. But anyway, to get to zero, we have to have $5,000 out of pocket max. So when we get there -- I mean it seemed to me I read someplace somebody making the point that for people whose incomes are $40,000 or

less, the choice with a high financial hurdle is not really a practical choice.

VICE-CHAIRMAN KERR: On the other hand, right now you have no choice. If it's your life and it's 5,000 versus your life and no choice, period, that individual has to make that decision. Obviously if you have more income, it's an easier decision.

CHAIRMAN ENTHOVEN: Right.

VICE-CHAIRMAN KERR: What this means is two things: Nobody's going to enter into this lightly. I mean it's not going to be a spurious type of situation. You're going to really think about it. It's going to have to be very meaningful for you as a consumer to use this option. But, secondly, if it is your life, you may find ways through family and every way else to find the 5,000.

MEMBER KARPF: The reality is people will -- most people will not use it. What this says is that 90 percent of the folks would stay in network -- 95 percent of those folks would stay in network, but the option is there. So one could no longer say "I couldn't have gotten out of there," which is what we've heard multiple times. And to me -- you know, I would ask Ron, what is the difference between a point-of-service product and a PPO? Is it just a financial barrier?

MEMBER WILLIAMS: It really has to do

with the centers to go in network and out of network.

MEMBER KARPF: Financial barrier.

MEMBER WILLIAMS: It's a financial cost. And the -- actually, cost is the biggest item.

The one other point I did notice on the study is that they do indicate that the -- for an individual in a small group, the cost would likely be greater. And so this reflects a more large group circumstance.

MEMBER KARPF: Let me set the record straight. This is not a study. What I asked people to do -- what I asked people to do is I asked them for my benefit before I supported this to see if there was any way this could be done that would be close to being neutral in terms of cost. And that's all it says. That there may be mechanisms of setting this up, and there will be very hard choices for individuals. But they will have the opportunity to make that value choice should they want to make that value choice. So this is not a study; it is a potential feasibility.

CHAIRMAN ENTHOVEN: This is getting long-winded. You did call it a UCLA study.

VICE-CHAIRMAN KERR: I just have a feeling this would be very popular with the public,

and it could be paid for entirely by the public

with potentially a zero premium increase.

CHAIRMAN ENTHOVEN: Okay. Rebecca Bowne.

MEMBER BOWNE: I think the more I hear you speak, the more I want to speak against this recommendation. It was just your last words as well as these, you know, circumstances such as life-threatening conditions. I think anyone who's looked at any kind of actuarial study whatsoever knows that it is a very small portion of the entire population that spends the very largest amount of medical expense. And the market has responded to that. We have HMOs with the point-of-service option, which is basically what you're advocating for here.

But the time to select that is when you select your plan, not when you have the medical condition. Because then that adversely shifts all of those with the highest medical costs into this box.

Now, I certainly applaud the idea of giving consumers more choice -- I mean clearly from where I'm coming from. But I don't think at the time you have the life-threatening condition is when you make it. That's when you have adverse selection.

VICE-CHAIRMAN KERR: But the problem is

about a quarter of all Californians do not have that choice.

MEMBER BOWNE: And it will not -- and 20 percent of Californians have no insurance whatsoever. This will aggravate this --

VICE-CHAIRMAN KERR: We realize that's one of the problems, too.

MEMBER BOWNE: Yeah. This will aggravate that situation. And the other thing is convening a working. And, frankly, it sounds like all the same players that are here. And I don't have much faith in them coming to a resolution.

CHAIRMAN ENTHOVEN: Decker -- Barbara Decker. Decker, Severoni, Zatkin and voting.

MEMBER DECKER: I feel like -- and maybe Clark's intent was to advocate for the specific approach. But I feel like the recommendation has been modified. And because it's modified to say explore ways to provide greater consumer choice, then it makes more sense -- I mean it's more acceptable to me. And I think we should stop being focused so much on whether this will work or not. I can tell you right now in looking on that data on here, the average pay at my company is now about 56,000 a year. Our deductibles are 100 -- no, $200 to go out of network. And we have about 85 percent in-network utilization.

So I'd say this model is understating the

cost effectiveness of it based on -- you know, we have a group that can easily move outside. They have less of a barrier than this, and their utilization is around the same as the projections are.

So you can go into this with all kinds of detail if you want to, but I don't think we should be focused on this as the answer. I think we should be focused on whether we want a group to explore other ways to provide consumers more choice of provider.

MEMBER ZATKIN: And you want to put a period after that, or do you want to designate this specific approach? Because that's what's objectionable.

MEMBER DECKER: I'm not the author. But I personally would be very amenable to saying "such as" and list stuff instead of making it so directive. I don't know if Clark's willing to do it at this point.

VICE-CHAIRMAN KERR: Certainly. I mean that was the intent. Let me read it again, the parts that we've added: "How to increase consumer choice of provider including consideration of such things as." That was one example.

CHAIRMAN ENTHOVEN: Zatkin.

MEMBER SEVERONI: Severoni.

CHAIRMAN ENTHOVEN: Oh, excuse me.

MEMBER SEVERONI: That's okay, because I'm going to ditto with decker and Romero and just leave it at that.

CHAIRMAN ENTHOVEN: Thank you for that concise --

(Multiple speakers.)

CHAIRMAN ENTHOVEN: Are you going to repeat yourself?

MEMBER ZATKIN: No. I'm going to just tell Michael that I doubt that your consultants talked to us in terms of what would make this cost neutral for the largest program in the state.

MEMBER KARPF: How much -- I was all (inaudible). They didn't talk about a whole lot of things. All they did was throw a bunch of numbers, actuarial quick, actuarial study. This is not a study. This is, essentially, let's get it to whether it can be in the ballpark or not. If they said it's going to increase premiums by 10 percent, I'm against this. No question. Because that will decrease access in the long haul.

MEMBER ZATKIN: Michael, I just want to say that the focus is misguided. Because if the issue -- and I think it went to an earlier discussion we had. Our health plan integrated programs utilizing high-quality providers to provide care -- specialty care. That's the issue. Because you don't want -- you don't want somebody

who is at the end of life scrambling basically, reaching out to anyplace and not having coordinating integrated care.

CHAIRMAN ENTHOVEN: I actually agree with that. And I actually was intrigued by the Troner Paper, because that really focused on the issue of how do you -- if people want to opt out or if people want alternatives, how do you make sure they go to the right alternatives as opposed to the wrong alternatives. I agree with that. That is an issue that needs to be fleshed out if the Committee feels that this issue should be studied further. Because I will --

VICE-CHAIRMAN KERR: I would insist they go to a provider.

MEMBER KARPF: I will guarantee if you want an opinion in medicine, whatever opinion you want, you will find it.

CHAIRMAN ENTHOVEN: Right. Thank you. And, Michael, I want to express my personal appreciation for your efforts at going out and having this study done.

MEMBER KARPF: I did it for myself.

CHAIRMAN ENTHOVEN: Is there a motion?

DEPUTY DIRECTOR SINGH: Is there a motion to adopt --

CHAIRMAN ENTHOVEN: Was that a motion?

MEMBER FARBER: I'll make a motion.

CHAIRMAN ENTHOVEN: Is there a second?

MEMBER FINBERG: I second.

CHAIRMAN ENTHOVEN: Okay. All those in favor of this motion, please raise your right hand?

DEPUTY DIRECTOR SINGH: Those opposed? Fourteen to eleven. The motion has not passed.

MEMBER LEE: Could I propose an amended version, which would put a period after provider -- choice of providers and other options and not go -- continuing along with the opt-out. So instead it's looking at how to expand consumer choice and other options. Clark, could you please read that.

VICE-CHAIRMAN KERR: I accept that as a friendly amendment.

MEMBER LEE: Could you please read it because you've got it.

VICE-CHAIRMAN KERR: Read the whole thing?

MEMBER LEE: Yeah.

VICE-CHAIRMAN KERR: It would read "The Legislature and Governor should convene a working group of stakeholders including health plans, providers, purchasers and consumers to examine the issue of how to increase consumer choice of provider."

CHAIRMAN ENTHOVEN: What about the

cost-neutral basis?

VICE-CHAIRMAN KERR: We can add that if you like.

MEMBER LEE: Sure.

VICE-CHAIRMAN KERR: "On a cost-neutral basis."

CHAIRMAN ENTHOVEN: All right. That's a motion.

MEMBER LEE: So moved.

CHAIRMAN ENTHOVEN: Second?

MEMBER SCHLAEGEL: Second.

CHAIRMAN ENTHOVEN: Okay. All in favor, please raise your right hand.

DEPUTY DIRECTOR SINGH: Those opposed? Twenty-three to two. The Recommendation is adopted as amended.

CHAIRMAN ENTHOVEN: Now, Michael, were you working on another -- were you working on language for this? -- Michael Karpf.

MEMBER KARPF: No.

CHAIRMAN ENTHOVEN: Okay.

MEMBER KARPF: I've had enough discussion of this issue.

CHAIRMAN ENTHOVEN: Okay. I didn't want you to feel suppressed by the Chair.

MEMBER KARPF: No, I haven't felt that way, Alain.

DEPUTY DIRECTOR SINGH: Members, can we

have a vote then to adopt the Findings and Recommendation section now as amended.

MEMBER LEE: So moved.

UNIDENTIFIED SPEAKER: Second.

UNIDENTIFIED SPEAKER: Second.

DEPUTY DIRECTOR SINGH: Those in favor, please raise your right hand.

Those opposed?

Twenty-four to two. The Findings and Recommendation is adopted.

MEMBER BOWNE: For entirely opposite reasons, we voted the same way.

CHAIRMAN ENTHOVEN: We're doing wonderfully well. We've still got four or five hours to go.

MEMBER FINBERG: Three hours, Alain. Could you tell us the order that we're going to go through the Papers, Alain?

MEMBER KARPF: Are there any slam dunks in there that can be done?

CHAIRMAN ENTHOVEN: Okay. We're going to come back to that Physician/Patient, Item 5.

DEPUTY DIRECTOR SINGH: Members, you have before you language that was prepared thanks to Ms. Griffiths' staff who typed up. In any event, the substitute recommendation No. 5 for the Physician/Patient Relationship recommendation is Tab No. 6-D. I believe that Members were in

concurrence with this Recommendation. Is there any further discussion before we have a motion to adopt this Recommendation?

(Multiple speakers.)

MEMBER ZATKIN: We haven't had any discussion.

DEPUTY DIRECTOR SINGH: I'm just trying to get through this as quickly as possible.

MEMBER SEVERONI: We didn't talk about it yet.

DEPUTY DIRECTOR SINGH: Okay.

MEMBER ZATKIN: We just saw it.

DEPUTY DIRECTOR SINGH: I know. I thought we talked about it in concept before.

MEMBER GILBERT: Alice, two comments: The first one is basically about adding the comments related to patient access and rights with respect to their medical records. I don't think we need to put "access" twice unless Diane -- I don't know if you want (inaudible). The second one is not an author's amendment. That was put in because one of the Task Force Members pointed out that there had been discussion around this issue at one of the previous Task Force meetings. So we wanted to put it to the group for discussion. But it's not necessarily the author's amendment.

MEMBER ZATKIN: Can you explain B?

MEMBER GILBERT: I'll let the author

explain B.

MEMBER SHAPIRO: Steve, can I explain B with the indulgence of the Chairman? It was -- in the last meeting, there was discussion on privacy. And in the transcript of that meeting, I indicated that, in fact, in many respects existing law which authorized the protection of medical information was quite good. And that the oversite hearings in the Legislature found some cases where as a condition for signing up with a health plan, enrollees were asked to waive their rights with regard to medical information which could then be used for commercial purposes, not the purposes listed in 5, the very last clause.

So I'm not wedded to the language in B. The thought was that you can't ask people -- you can ask people to waive and offer consent for purpose of health care and payment and service and all the things listed. But beyond that, you shouldn't be able to ask someone to waive their rights and then allow the information to be used for commercial purposes. That's how the law has been (inaudible) circumvented.

The protections are fine, but you can literally ask someone to sign away their confidentiality.

MEMBER ZATKIN: Can you draft it more narrowly than this?

MR. SHAPIRO: Pardon?

MEMBER BOWNE: It's too broad.

MR. SHAPIRO: I'm actually open to reiterating the phrase in the final sentence to line five (inaudible) -- well, let's work on it. But the idea is to ensure that the items listed in 5-A are what you waive and nothing beyond that just because you're required to do that as a condition for getting care.

DEPUTY DIRECTOR SINGH: Mr. Kerr and then Dr. Spurlock.

VICE-CHAIRMAN KERR: Yeah, I had a question. This is only for individually identifiable data, I assume. Because if it's not, I hope that we will allow data to be pulled from everybody's records that's not individually identifiable but allows for research to advance evidence-based medicine. If we don't do that, then we've lost --

MEMBER FARBER: (Inaudible.)

VICE-CHAIRMAN KERR: It's just patient identifiable. You can certainly pull out information on an aggregate basis. Okay.

DEPUTY DIRECTOR SINGH: Dr. Spurlock.

MEMBER SPURLOCK: Michael, I think I know what you're getting at. I think Clark just sort of starting hitting on this thing about research. Patients can waive their right to

confidentiality for research purposes for the purposes of that study. It goes to institutional review boards and goes to other areas. And then patients come in and say "I want to participate in this study, which means medical information that's specific to me can be part of that study, but it's protected from anybody outside the study seeing it. That's one provision that's not in 5-A that I would hate that we would narrow out. Because, again --

MEMBER SHAPIRO: Why don't we put it in 5-A. I think that's and actual -- people have been getting that information now for research purposes. Or in B we can be specific about not for commercial purposes.

MEMBER SPURLOCK: I think that's a narrowing of B, so that we don't forget something that we might have -- I mean not a thought that's really critical in delivering care.

MR. SHAPIRO: So why don't we put in that they can't sign a release consent form which would permit such information be used for commercial purposes not associated with those things (inaudible).

DEPUTY DIRECTOR SINGH: Ms. Farber.

MEMBER FARBER: Just as a point of clarification, there's extensive consent law in the state of California that already governs this issue that protects patients participating in

institutional review board activities and research projects. And there are very specific federal and state guidelines that already apply. There's no point in rewriting them. I believe that patients are adequately protected from that standpoint. The point of departure is precisely the one that you brought up which is commercial purposes.

DEPUTY DIRECTOR SINGH:

Dr. Rodriguez-Trias.

MEMBER RODRIGUEZ-TRIAS: My understanding of B is that the key words here is "as a condition for securing health care services" in the second line. So that it's not just a general statements; it's very specific on obtaining consent as a condition that is waiving the confidentiality or obtaining consent for access to medical information as a condition of giving care.

MEMBER SHAPIRO: I would be comfortable with the commercial emphasis that (inaudible), which waives any medical (inaudible) which allows for the commercial use of such information.

DEPUTY DIRECTOR SINGH: I'm sorry, Mr. Shapiro, I can't understand a word that you're saying when you're talking about the commercial -- is there an amendment that you're suggesting -- a technical amendment?

MEMBER SHAPIRO: Can I get back to

you? I'd like to draft something and share it, and

then come back. Is "A" done?

DEPUTY DIRECTOR SINGH: Let's move to discussion on 5-A. Is there discussion? Are Members ready to make a motion to adopt Recommendation 5-A?

Ms. Decker.

MEMBER DECKER: I'm sorry, I don't understand the purpose behind 5-A. Can whoever is advocating for it explain what we're trying to do?

DEPUTY DIRECTOR SINGH: Dr. Gilbert.

MEMBER GILBERT: Diane, do you want to comment? Because most of the additional language is from you.

MEMBER GRIFFITHS: Yeah.

I raised the issue that in the Clinton proposal that was circulated to us, there was a suggestion that there was a need for some additional confidentiality protections. And Sarah and I worked out this language to ensure that the state law would be consistent and that the state law would be reviewed to ensure that confidentiality -- that individually identifiable health care information wouldn't be circulated to the detriment of the patient except for the purposes that would be necessary for obtaining treatment and for obtaining payment, including all the various activities that the health plan would

need to undergo to ensure the payment mechanisms

were followed.

MEMBER GILBERT: As I read (inaudible), the first step is monitor any substantive changes at the federal level that, in fact, could improve confidentiality or access and, two, to review state law to make sure everything holds in regard to confidentiality or access to medical records. Is that fair?

MEMBER GRIFFITHS: Yes.

DEPUTY DIRECTOR SINGH: Mr. Schlaegel.

MEMBER SCHLAEGEL: There was a question about whether research needed to be added to "A". Is that still an issue?

MEMBER FARBER: It's already covered in an existing consent law, what you can do and what you can't do with patient confidentiality when they're participating in clinical trials and in human experimentation.

CHAIRMAN ENTHOVEN: What about outcomes research in general?

MEMBER FARBER: Outcomes research, I think, is probably why you want 5-A. And it's not mentioned specifically, but this is a new application of patient data. And I think what the intent behind this is is to extend the same confidentiality standards to outcomes research

which this group believes to be so very necessary, but it needs to be protected just as it is when

patients participate in clinical trials and their records are reviewed at the institutional review board meetings.

MEMBER GRIFFITHS: As you know, Mr. Chairman, that is -- thank you for that helpful reminder. That's where this idea grew out of is the discussion about using this outcome (inaudible) adjustment and those --

MEMBER SPURLOCK: Well, it's hard to make a distinction.

CHAIRMAN ENTHOVEN: I'm not clear on -- is outcomes research included in here by implication?

MEMBER FARBER: I think it probably should be explicitly included.

CHAIRMAN ENTHOVEN: Okay. Outcomes research, risk adjustment.

VICE-CHAIRMAN KERR: Outcomes research and (inaudible) evidence medicine, too.

CHAIRMAN ENTHOVEN: Is that all right? We can include that, outcomes research, risk adjustment.

VICE-CHAIRMAN KERR: Risk adjustment and also advanced evidence-based medicine. That's more than just an outcome diagnosis.

MEMBER GRIFFITHS: Where are you adding

it to the (inaudible)?

VICE-CHAIRMAN KERR: To what he's

adding it to.

DEPUTY DIRECTOR SINGH: In the second-to-the-last line of 5-A after "health care," you would insert "outcomes research, risk adjustment" --

VICE-CHAIRMAN KERR: And "research to advance evidenced-based medicine."

MEMBER GRIFFITHS: I'm not quite sure what that means in the absence of some other language saying only insofar as is necessary. I mean we don't want it to be a blanket authorization for --

CHAIRMAN ENTHOVEN: I know what "outcomes research" means, which is analyzing databases looking for patterns of care and patterns of outcomes and seeing if you can find relationships that say this pattern of care produces this good outcome.

Bruce.

MEMBER SPURLOCK: It doesn't always mean that. It may mean an individual patient's concerns in situations. For example, very large cardiovascular studies that are multi-institutional within that research group has access to individual identifiable information to track that. Once it

gets past the research stage into the publication stage, it's not, therefore, any longer identifiable. But you could participate in

multiple settings, large outcomes research studies where the individual research participants would need to have that data. So it's not just looking at databases.

MEMBER GRIFFITHS: You know, what's missing from this draft is -- Sarah and I have had various iterations of this. And the one that was circulated before this had a couple of sentences about when disclosure is required, no greater amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure. That language got dropped out, I believe, from this version. And if a longer list of exceptions are to be added, then I think it would be necessary to have that --

DEPUTY DIRECTOR SINGH: In the original Recommendation No. 5.

MEMBER FARBER: Could you restate the language again that was missing.

MEMBER GRIFFITHS: It's in No. 5 of the original document circulated, second-to-the-last sentence, and I'll read it: "When disclosure is required" --

MEMBER FARBER: Okay. I see it.

MEMBER GRIFFITHS: -- "no greater

amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure."

DEPUTY DIRECTOR SINGH: So you're proposing that we move sentence into the new 5-A?

CHAIRMAN ENTHOVEN: Yeah, to the bottom of 5-A?

MEMBER GRIFFITHS: Yes.

DEPUTY DIRECTOR SINGH: Is there any objection?

Is there further discussion before a motion is made to adopt 5-A as amended?

MEMBER GRIFFITHS: Yes. I would suggest also the sentence that followed in the old 5 as well, "otherwise information should not be released unless authorized by patient consent or by law."

DEPUTY DIRECTOR SINGH: Is there any objection?

MEMBER NORTHWAY: Just a clarification, then. So it's going to be the new 5-A plus the last two sentences of the old 5?

CHAIRMAN ENTHOVEN: Yeah.

MEMBER NORTHWAY: Is that correct?

CHAIRMAN ENTHOVEN: Right.

MEMBER BOWNE: Plus the other language.

DEPUTY DIRECTOR SINGH: Plus the other

language, "the outcomes research, risk adjustment and research to advance evidence-based medicine."

MEMBER NORTHWAY: And that comes after --

DEPUTY DIRECTOR SINGH: That comes after -- in the second --

MEMBER NORTHWAY: -- "investigation of grievances" or no?

DEPUTY DIRECTOR SINGH: This is -- the second-to-the-last sentence says "of health care" and then you insert "outcomes research" --

CHAIRMAN ENTHOVEN: Insert --

DEPUTY DIRECTOR SINGH: -- and so forth. "Outcome research, risk adjustment and research to advance evidence-based medicine."

Is there a motion to adopt Recommendation 5-A?

Mr. Schlaegel.

MEMBER SCHLAEGEL: So moved.

DEPUTY DIRECTOR SINGH: Second?

MEMBER SPURLOCK: Seconded.

MEMBER FARBER: Second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting 5-A as technically amended, please raise your right hand.

Those opposed?

Ms. O'Sullivan, are you opposed?

MEMBER O'SULLIVAN: No. I'm slow.

DEPUTY DIRECTOR SINGH: Twenty-three to zero. Recommendation 5-A is adopted.

MEMBER GILBERT: 5-B. "No health plan or any of its contractors should be allowed to

require an enrollee as a condition for securing health care services to sign a release or consent form which waives any medical information confidentiality protections for the purpose of using such information for commercial purposes."

DEPUTY DIRECTOR SINGH: Could you read that one more time.

CHAIRMAN ENTHOVEN: Could you start with what's there.

MEMBER GILBERT: I did all the way through -- if you go just to "confidentiality protections," it's all the same except we get rid of one of the medicals. There's two medicals. "Protections for the purpose of using such information for commercial purposes. And therefore authorized by law" (inaudible).

CHAIRMAN ENTHOVEN: Uh-huh.

DEPUTY DIRECTOR SINGH: Is there objection to that technical amendment?

CHAIRMAN ENTHOVEN: Did you say "authorized by law" goes out, then?

MEMBER GILBERT: Correct.

MEMBER RODRIGUEZ-TRIAS: I have a

question. Why are we limiting it? Because, again, I think the key words here "as a condition for securing health services" -- is there any circumstance in which you waive confidentiality as a condition for receiving health services?

EXECUTIVE DIRECTOR ROMERO: Yes, and for the reasons in 5-A.

MEMBER GILBERT: Yeah. In other words, they're going to list all the reasons in 5-A.

EXECUTIVE DIRECTOR ROMERO: The reasons in 5-A are for purposes of serving you and your health care. Once you get beyond that point -- and we've seen information sift into pharmaceutical companies and other companies because there's a loophole here. This makes clear that you can be asked to waive it for these purposes in 5-A. But beyond that, it shouldn't be used for commercial purposes.

DEPUTY DIRECTOR SINGH: Is there a motion to adopt 5-B?

I'm sorry, Dr. Spurlock.

Second?

MEMBER FARBER: Second.

DEPUTY DIRECTOR SINGH: Those in favor, please raise your right hand.

Those opposed?

Twenty-one to zero. Recommendation is adopted.

MEMBER FARBER: Alice, could you tell me what the vote was on 5-A?

DEPUTY DIRECTOR SINGH: 5-A was adopted 23 to 0.

MEMBER FARBER: Thank you.

CHAIRMAN ENTHOVEN: All right, Class. I propose that we next take up Dispute Resolutions, but we'll have to do two more topics to meet our time to take -- offset the fact the Regulatory Organization is going tomorrow morning. But first we'll have a brief interlude. I want to call on Ms. Leanne Tratler of the Consumer Attorneys of California. She's asked if she could be allowed to speak now because she has a sick child. And as a quid pro quo, I've got some kind of commitment from her and Mark that the Consumer Attorneys' statements will be consolidated into one presentation.

Thank you for coming, Ms. Tratler.

MS. TRATLER: Thank you very much for permitting me to -- can you hear me?

(Multiple speakers.)

MS. TRATLER: Thank you for permitting me to speak at this time. My name is Leanne Tratler. I'm legal counsel for Consumer Attorneys of California.

First I'd like to commend the Task Force

for examining the issue of the possible causative effects of the liability system on ensuring accountability have HMOs and acknowledging the problems that we face at the federal level like the ERISA preemption.

However, Recommendation 3 falls short of

the goal. By its statements that would discourage the filing of lawsuits, the Recommendation effectively looses its teeth. The problem is, first, the reference to the costly lawsuits is without empirical foundation. The experience -- the only experience that we've seen in another state that has employed a liability system is Texas, which enacted a liability law last year. And in my letter I said it was with the signature of Governor Bush. And I apologize. It was enacted without his signature. But, nevertheless, it did become law.

And the experience of Texas shows that there has not been a flood of lawsuits in the end response to the new legislation. The reasons are probably many. But one, these are very difficult lawsuits to pursue. The lawyers would have to have a tremendous amount of expertise. And they're also very expensive to pursue.

Secondly is the Kaiser Foundation study that examined SB977, which is a Bill by Senator Keyes that would impose liability against

HMOs for interfering with medical treatment decisions. It does not have caps in that Bill. The Kaiser Foundation study looked at that, did not see the problem with lawsuits that apparently are reflected in this Recommendation and, with regard to IPAs, indicated there would only be a .2 to .4

percent increase in premiums.

Secondly, the problem with the limitation of liability language in the Recommendation is that it limits the effectiveness of holding an HMO accountable for their medical treatment decisions.

When a billion-dollar corporation is permitted to make a business judgment that it's cheaper to deny care and possibly face a limited liability, then you have really eviscerated the purpose of accountability in the first place. And it finally just bolsters the public's perception that HMOs put profits over people.

By imposing in this Task Force Recommendation a finding that you want to limit the accountability of an HMO that is interfering with the quality of care, you're just feeding the public's fears.

We would ask that the Commission amend the Recommendation to reflect a statement of intent that HMOs should be accountable. And we would ask that the Federal Government address that problem in

the ERISA Statute and not address the liability issues at this time as they're without empirical foundation.

Thank you.

CHAIRMAN ENTHOVEN: Thank you.

All right. Now we are going to take up Dispute Resolution.

DEPUTY DIRECTOR SINGH: That's Item 6-F.

MEMBER O'SULLIVAN: Can you tell us what your plan is for the one after Dispute Resolution.

CHAIRMAN ENTHOVEN: Let's see. I think -- what were you thinking? Well, we need to make up for the time of Regulatory Organization. One possibility -- I mean we could do -- try to do New Quality Information and Women. Dispute Resolution now and then two more.

(Multiple speakers.)

CHAIRMAN ENTHOVEN: Maryann, I think we'll do Dispute Resolution and then at least take up one more, which might be Vulnerable Populations. How about that?

Yes, Nancy.

MEMBER FARBER: Can I ask a question about this Paper.

CHAIRMAN ENTHOVEN: Yes. Which one?

MEMBER FARBER: The Paper about Dispute

Resolution. There may be somebody that can tell me what the legal requirement is. But one of the things that was important in this Paper was the time frame in which a health plan has to take up an enrollee's complaint. And on page 4 --

MEMBER LEE: We're going to go recommendation by recommendation.

MEMBER FARBER: But I want to ask a question because it will affect -- they were talking about having to respond within five days. But the question that I have is there anything in existing statute that defines when the complaint is formally lodged? I mean is it when the patient first calls the health plan and expresses a verbal complaint, or is there a requirement that this complaint has to exist in written form? Does anybody know if there are any standards related to that?

EXECUTIVE DIRECTOR ROMERO: Nancy, we've Knox-Keene here, and we will look into it. I don't think we have anybody from the DOC.

DEPUTY DIRECTOR SINGH: Yes, we do. We do have a representative from the Department of Corporations here that we can answer that question.

CHAIRMAN ENTHOVEN: Please stand up.

DEPUTY DIRECTOR SINGH: This is Ms. Barbara Gilmore.

MEMBER FARBER: I'm just wondering what triggers the clock running?

MS. GILMORE: Between the statute and the regulations, the Department views that the clock is running whenever a health plan receives a complaint, whether they receive it over the telephone or in writing.

MEMBER FARBER: Okay. Thank you.

MEMBER DECKER: Can you clarify at where we're starting and how long we've got.

CHAIRMAN ENTHOVEN: We are starting, and we want to try to do this in an hour and a quarter. So 5:45. And Barbara is going to help push us along. So if we can move to the recommendations.

Peter, do you want to --

MEMBER LEE: I'll follow the procedure we've gone through and go through each recommendation. On many of them they're small, technical amendments. I think on many also -- though, I know this section has been accused of being overly long, I think there's a lot agreement on. So I think we can go through them very quickly.

Starting with No. 1 on top of page 3, I have no technical recommendations or amendments, and I'd entertain any and hope we can get it approved quickly. If there are no comments or

changes on 1, I would move No. 1.

MEMBER FINBERG: Second.

CHAIRMAN ENTHOVEN: All in favor.

We're voting on No. 1.

EXECUTIVE DIRECTOR ROMERO:

Recommendation No. 1 on the top of page 3.

DEPUTY DIRECTOR SINGH: Opposed?

Sixteen to zero. The Recommendation has

been adopted.

MEMBER LEE: As a group recommendation 2-A, B and C. I have no technical recommendations on them for amendments proposed. And I would entertain any comments, suggestions to make such. And hearing none, I would move adoption of 2-A, B, C.

DEPUTY DIRECTOR SINGH: Is there a second?

MEMBER FARBER: Yeah.

CHAIRMAN ENTHOVEN: Okay.

DEPUTY DIRECTOR SINGH: Those in favor of Recommendations 2-A, B and C please raise your right hand.

Those opposed?

The recommendation is adopted, 20 to 0.

MEMBER LEE: Moving to 3-A. And I'd like to have this combined, 3 and 3-A. No technical or correcting amendments proposed. I

would like to entertain any to see if people have any proposals to change, clean up anything in 3 or 3-A.

MEMBER FARBER: Second.

MEMBER LEE: Hearing none, I move it. It's been seconded by Nancy.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation 3-A, B --

MEMBER LEE: Just 3 and 3-A.

DEPUTY DIRECTOR SINGH: 3 and 3-A, please raise your right hand.

Those opposed?

The Recommendation is adopted 19 to 0.

MEMBER LEE: Okay. Now I've got a couple -- some cleanup languages. I'd like to treat as a group B-1 and B-2. First, amendments to B-1. It would be amended to read "Currently Knox-Keene regulated health plans are required to respond to non-urgent grievances" instead "complaints." Substitute the word "grievances" for "complaints" -- "within 30 days, whenever possible." The next sentence, the parenthetical has been noted to be almost nonsensical. So edit it to read "e.g., when" -- delete "issues required" -- so it's going to read "when complex medical issues" -- delete "that" -- "need to be researched" -- close parens, and then insert "when the time frame may be longer." Okay. That's what

I call technical amendments.

MEMBER FARBER: I don't understand. I'm not following you.

MEMBER FINBERG: Would you read after "e.g." again.

MEMBER LEE: "E.g., when complex medical issues need to be researched is what the e.g. is.

DEPUTY DIRECTOR SINGH: You're deleting

"that need to be researched"; correct?

MEMBER LEE: No, I'm leaving in "need to be researched." What it will read is "e.g., when complex medical issues need to be researched."

CHAIRMAN ENTHOVEN: "When the time frame may be longer."

MEMBER LEE: Right, "when the time frame may be longer."

MEMBER DECKER: Why don't you read the words that are deleted just to be sure.

MEMBER LEE: I'm deleting the words "issues require" and "that."

MEMBER FARBER: Peter, are you willing to put any kind of outside limit on that 30 days?

MEMBER LEE: Pardon me?

MEMBER FARBER: I mean you've already said, you know, they're going to go beyond 30 days. Is there a not-to-exceed concept here? I mean

theoretically they could research it for the next 365 days.

MEMBER SHAPIRO: There's a statutory ceiling of 60. Not that they can't go beyond 60 days, but at that point, the enrollee has the option, if they so choose, to go with the Department of Corporations. Most of them stay with the plan because they're working with the plan to get that information. But that option is there.

MEMBER LEE: We aren't suggesting to

change that beyond the 60 days currently in law. The other change on 2 is if you go to the bottom of 2 is -- after it says "within 72 hours," start an open parens. So open parens "as required by the Health Care Financing Administration," close parens, delete all the rest, which is -- this is all just describing sort of internal HCFA stuff which I think makes it confusing. Then after the parens, "instead of the five days currently required."

MEMBER HARTSHORN: I'm sorry, could you read it -- I'm lost.

UNIDENTIFIED SPEAKER: Could you read the parenthetical.

MEMBER LEE: Yeah. What it's going to read is "The Governor and the Legislature within two years whether all plans should be required to respond within 72 hours (as required by the Health

Care Finance Administration) instead of the five days currently required."

CHAIRMAN ENTHOVEN: Peter, what this means is -- B-1 is they have to resolve them in 30 days instead of 60 days.

MEMBER LEE: No. The change that this makes from current Knox-Keene, as I understand it, is Knox-Keene does not say you have to resolve it in 30 days; you have to respond within 30 days. This is saying that the response -- the resolution

should be in those 30 days. That's the change from what is currently on books.

DEPUTY DIRECTOR SINGH: Peter, I'm sorry, the statute actually says "resolve whenever possible within 30 days" now.

MEMBER LEE: Right.

MEMBER SHAPIRO: So you aren't changing --

MEMBER LEE: It's "resolve" or --

DEPUTY DIRECTOR SINGH: "Resolve."

UNIDENTIFIED SPEAKER: I thought that was resolved. Okay.

MEMBER BOWNE: The statute says "resolve."

MEMBER SHAPIRO: So do we want --

CHAIRMAN ENTHOVEN: Yeah. Do we need one --

DEPUTY DIRECTOR SINGH: The idea was to make it consistent for plans that weren't Knox-Keene plans.

MEMBER LEE: Right.

MEMBER FARBER: "Respond" is definitely different than "resolve." It's a lower standard.

MEMBER DECKER: So we need to change the "respond" on the first line to "resolve" because we're saying what's current.

CHAIRMAN ENTHOVEN: "Are Required to resolve non-urgent grievances within 30 days

whenever possible." Is that right?

MEMBER LEE: For the Department, is that true that the 30 days -- could we have a quick cite that it's "respond or resolve" within 30 days currently under Knox-Keene. I didn't mean to put you on the spot here. You probably have a quicker cite to where this is than I do.

MS. GILMORE: It's in Section 1368.01 Subsection A. The grievant system plan is required to put in place -- shall require the plan to resolve grievances within 30 days whenever possible. It shall require the plan to provide enrollees and subscribers with a written statement on disposition or pending status within 30 days. So it's both "resolve" and "respond."

MEMBER LEE: So let's amend the first line "resolve" as well. And then the effect is to

cut across to non-Knox-Keene plans.

DEPUTY DIRECTOR SINGH: "Respond" and "resolve."

MEMBER RODRIGUEZ-TRIAS: But, Peter, are you going to include "The Task Force recommends that all plans" -- because -- I mean when I first read that, I said "So what's he saying?" What's the difference between what's Knox-Keene and what we're suggesting.

CHAIRMAN ENTHOVEN: That's what you mean, all plans.

MEMBER LEE: Yes. It should amend also then that "all plans."

CHAIRMAN ENTHOVEN: I.e., non-Knox-Keene.

MEMBER RODRIGUEZ-TRIAS: Yeah.

CHAIRMAN ENTHOVEN: May we just do that to make it clear to people, non-Knox-Keene?

MEMBER FINBERG: So that's the third -- three, four lines up from the bottom?

MEMBER SEVERONI: That's No. 1.

MEMBER LEE: No, that's No. 1.

DEPUTY DIRECTOR SINGH: Why don't you read it one more time, Peter.

MEMBER LEE: I believe "Currently Knox-Keene regulated health plans are required to respond and resolve non-urgent grievances within 30

days whenever possible. The Task Force recommends that all plans, e.g., including non-Knox-Keene plans be required to resolve non-urgent complaints within 30 days except under special circumstances, e.g., when complex medical issues need to be researched, when the time frame may be longer."

CHAIRMAN ENTHOVEN: It says "e.g., all non-Knox-Keene plans" other than ERISA plans?

MEMBER LEE: We don't need to put that. If we get ERISAs that jump in here, too, that's great.

CHAIRMAN ENTHOVEN: All right. Okay.

All right. So that's B-1. B-2 has been modified.

Any further discussion on B-1 and 2?

MEMBER FARBER: I have question about 2. Do you intend to extend the resolve requirement to B-2? Not respond, but to include the Knox-Keene standard which is involved?

MEMBER LEE: I think -- yes, that's a friendly amendment.

MEMBER FARBER: Thank you.

DEPUTY DIRECTOR SINGH: Is there a motion to adopt Recommendation B-1 and 2?

MEMBER FARBER: So moved.

MEMBER GILBERT: Wait. Can we ask if the standard now is resolve or respond for the five-day urgent complaints? Is that resolve in five days?

MEMBER ZATKIN: I believe it is. Can we confirm that?

UNIDENTIFIED SPEAKER: Yes.

MEMBER DECKER: "Yes" what?

UNIDENTIFIED SPEAKER: Whenever possible.

MEMBER DECKER: Respond or resolve?

MEMBER ZATKIN: Could you read the provision, please.

MS. GILMORE: I'm looking for the exact language.

MEMBER BOWNE: Mr. Chairman, I have a

broader question, while she's answering that, as well. I'd like to know what is the capability of the Knox-Keene plans to respond and resolve within this time frame? In other words, are they generally doing it? Are there a lot of exceptions? So -- you know, before we spread it -- and if somebody knows --

MEMBER SHAPIRO: Actually, they're generally doing it in a much shorter time than five days. They're generally doing it the same day in most cases. But -- so we negotiated a very liberal rule for unusual cases. And what we discovered later, we might have been too liberal. We haven't had complaints about this issue but just two different standards and different laws at the

moment. They do it very rapidly, usually the same day.

MEMBER LEE: The language on the five days, just to read you what it is currently, and then we can move through, "shall require a plan to provide enrollees, subscribers with a written statement of the disposition or pending status within five days. So it doesn't require resolution; it requires really response is appropriate on the five days in terms of what it is under current law. It doesn't require a resolution; it requires a response within five days.

CHAIRMAN ENTHOVEN: Peter, could you tell us something about the costs versus the benefits of that? I mean it sounds like it's probably very few people who are affected.

MEMBER LEE: Well, it's a few people who are affected. Again, I think that in the short turnaround, the vast amount of plans are meeting the five days. And we have the language here to look at should it be three versus five over a period of time.

CHAIRMAN ENTHOVEN: To look and can do a cost-benefit evaluation.

MEMBER LEE: That's exactly what we're asking for on No. 2. We aren't changing the five days in No. 2. We're saying one of the things we

want throughout here is try to have consistency. Right now in Medicare there's a different standard.

CHAIRMAN ENTHOVEN: Got it. Okay. All right. Do we have a motion?

DEPUTY DIRECTOR SINGH: Do we have a motion to adopt --

MEMBER FARBER: Mr. Chairman, what is the language going to read? Is it going to read "respond," or is it going to read "resolve"?

MEMBER SEVERONI: "Respond."

MEMBER BOWNE: "Respond in five days."

MEMBER FARBER: I have a philosophical problem with that from the standpoint that you can

respond and fail to resolve, and there's no outward limit. And sometimes those decisions can make the difference between life and death for people. And so there you are leaving it with a simple response. The response can be "no." Then what?

MEMBER LEE: Part of the point -- if the response -- or at any point a resolution is "no," the point is to give someone the knowledge to then appeal to the next level. I mean the restitution required by the dispute process is not the one every consumer would want. You need to get a fast answer, though, so if they want and need to appeal, they can do it --

MEMBER FARBER: That's what I get

concerned about is health plans dragging out on a appeals process past the point where a patient can benefit from a therapy. And that's a very scary thing, and that happens. And you can play games with appeals and denials. You know, then you appeal to a higher authority. And pretty soon the patient's in no condition to benefit from what an early intervention might have proved to be the difference between life and death. So where does this end? Where do we protect the consumer?

MEMBER LEE: I mean I feel that what this Recommendation is is, again, being -- trying to improve the consistency between what's between Medicare and Knox-Keene now and trying to push

towards that. We originally proposed having a 72-hour across-the-board amended (inaudible), some of the votes there in terms of having a proposed amendment to say "resolve" here. The concerns I know the plans have is that's a very fast turnaround and may require more research. But they can absolutely say "Here's where we stand" and provide that in writing within that very short time.

MEMBER FARBER: I guess -- you know, if the presumption is that everybody's acting in good faith, that's well and good. But I think there's already adequate documentation in legal history that not all plans act in good faith.

MS. GILMORE: Just a matter of clarification. The Legislature chose to use "resolve" in one instance and "disposition" in another. But in Section 1368.01(b) of the section that Member Lee just read, I read "disposition or pending status" as "resolution or pending status." The disposition means how it was disposed of. So both. So current law is "resolve" or "respond."

MEMBER LEE: Right. "Resolve" or "respond." And then simply change both of these to "resolve" or "respond." It doesn't get, as far as Nancy would now term it, have to resolve, but it provides an opening.

MEMBER FARBER: I go back to my point

on consumer protection. There has to be a point when the plan -- you can exhaust all the levels of the appeal in a plan and be owed an answer. And when medical necessitates such that time is of the essence, I think the consumers deserve to be protected.

MEMBER LEE: I don't have any argument. The point of having three days or five days when you have a written notice (inaudible) disposition, you've got something you can go to, quote/unquote, a higher authority. That's the point.

MEMBER BOWNE: Nancy, with all due

respect for consumer rights, which I think we would advocate, I do think that we have to give some modicum of credibility that most health plans act within the spirit of the law. And if they don't, they should certainly suffer consequences.

MEMBER FARBER: They do not suffer consequences. Now they're protected from consequences for their medical decisions. And -- so where does this end? Where does the consumer come out on top?

MEMBER LEE: I mean for here, though, saying "respond or resolve" says that whether it's three or five days, these two time frames, that starts the formal process of saying you disagree, and you can go to the next level. That's what this

does. The other levels we're going to get to in a minute.

MEMBER FARBER: But there's no limit to those levels.

MEMBER SEVERONI: No. I think if I heard this language correctly, what we're being told is that that first line should read "health plans must respond and resolve urgent complaints."

MEMBER LEE: No, it's "or." It's currently "or." And that's the --

MEMBER SEVERONI: It's not "and."

MEMBER LEE: Right. I mean the status of disposition provides the plan with the ability

the say "Here's what we've done in terms of research. And either we haven't made a determination" -- but that's the point for urgent appeals where the Department, by law, can and, as I understand, does on some circumstances step in. They've got that period within which the plans have the opportunity to do something.

MEMBER GILBERT: Peter, there's one other set of protections in the law. If you have a terminal illness, you have to have a hearing within five days of any denial of any of therapy for someone with a terminal illness. There's an additional protection for people that have been determined to have a terminal illness, which is defined as potentially causing loss of life in one

year, I believe, or six months. You have to have a hearing and actually bring in the patient to that hearing if there's any denial. Can we get the cite for that? That's an additional protection for individuals with a terminal illness already in law.

CHAIRMAN ENTHOVEN: We really need to be moving forward here.

MEMBER LEE: What this will be amended to read is "respond or resolve" in both places where it currently reads "respond" in B-2.

MEMBER FARBER: I don't think anybody's interested in what I have to say.

DEPUTY DIRECTOR SINGH: At this point in time Ms. Farber had moved to adopt. Is your motion to adopt still standing, Ms. Farber, this Recommendation?

MEMBER FARBER: No.

MEMBER BOWNE: Move adoption.

DEPUTY DIRECTOR SINGH: Second?

UNIDENTIFIED SPEAKER: I'll second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendations B-1 and 2 please raise your right hand.

Those opposed?

The Recommendation is adopted 20 to 0.

MEMBER LEE: Moving to C, Periods of Limitation, no cleanup amendments.

Any additional amendments, comments on

this one?

Hearing non, move adoption.

MEMBER DECKER: Second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation C.

Those opposed?

The recommendation is adopted 23 to 0.

MEMBER LEE: D. Now, I don't have a technical amendment. This is one of the places where there's cross-communication issues with the EOC groups that are working and also some other places. This is an example to me of how to

communicate in standard languages that I assume and hope that when the EOC groups look at these issues, they look at this. But I don't know if we have an amendment in here to do that.

So if anyone wants to make any amendments, the floor's open for D.

Move adoption.

DEPUTY DIRECTOR SINGH: Is there a second.

MEMBER SEVERONI: Second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation D, please raise your right hand.

Those opposed?

Recommendation is adopted 24 to 0.

MEMBER LEE: E is one that we've talked

about but did not do a straw pole on at the last meeting, which was the extent to which consumers have a right to appear in grievance processes in plans. A number of states have this requirement. California, as I understand it, does not. And this would allow that to make sure that consumers would at some point in the plan's process be able to appear in person. And the only technical amendment would be to delete the italics.

CHAIRMAN ENTHOVEN: Do people from the plans have comments on that?

MEMBER BOWNE: At what point along the way, and does this mean they have to appear --

MEMBER LEE: No.

MEMBER BOWNE: -- or they would have the opportunity and when would this happen?

MEMBER LEE: It would be to allow them to participate; it's not to say at which point. Most plans have two-step process. It would not say it would have to be at the first step, but it would have to be at one of the steps they would be able to appear.

MEMBER ZATKIN: Maybe you should say that rather than the way you worded it. To the extent possible, it seems to be both points.

MEMBER LEE: Okay. Do you have a suggestion?

MEMBER ZATKIN: If that's your intent.

MEMBER DECKER: Steve, I can't hear what you're saying.

MEMBER ZATKIN: I was suggesting that what Peter said was to allow people to appear at some point in the process is a little different from what this reads. This says "to the extent possible," which I would construe to mean at the very beginning and then thereafter, rather than what Peter says.

MEMBER DECKER: Would it help if we looked over on page 7, Item -- under E-6(b)? I

think that's where we actually discussed it the last time. And it talks about the kind of circumstances that had been anticipated.

MEMBER LEE: Really, the -- 6-B noted some of the ways the plans provide exceptions when people might not appear but can still be there by phone. And so it is sort of what we talked -- in the context we talked about it last time, was a number of plans that normally allow people to appear in person, but would even say you can appear by phone if not in person. But that is where we talked about it last.

I would say it would be a friendly amendment to amend what is here to say "Plans should allow members to participate in the grievance process in person at least at one hearing that the plan may hold."

CHAIRMAN ENTHOVEN: Any objection to that?

MEMBER SEVERONI: Can I just say I don't know -- my sense is that -- I know of plans that do encourage members to participate in this process or provide opportunities. And I guess my suggestion might be just instead of the language being "plans should allow," maybe "plans should allow opportunities for members to participate in the grievance process." It's just a better way of

saying it. I think there are plans --

MEMBER LEE: The point in the Recommendation is to make sure that every plan -- every consumer should have an opportunity to appear in person at least at one point in the process.

MEMBER SEVERONI: I agree with that.

MEMBER LEE: Then I'm not sure what the language you're suggesting is.

MEMBER SEVERONI: Well, I'm just saying rather than saying "should allow," I'm saying you could accomplish the same thing by saying "should provide opportunities."

MEMBER LEE: I think "should provide" si fine instead.

DEPUTY DIRECTOR SINGH: Any objection?

MEMBER WILLIAMS: What does "provide opportunities" mean?

MEMBER LEE: It means allow.

Move adoption.

CHAIRMAN ENTHOVEN: Second?

DEPUTY DIRECTOR SINGH: Is there a second?

Those in favor of adopting Recommendation E, please raise your right hand.

Mr. Lee, would you like to read what it says.

MEMBER LEE: "Plans should provide opportunities for members to participate in the

grievance process in person at least at one hearing that the plan may hold."

CHAIRMAN ENTHOVEN: "To the extent possible."

MEMBER LEE: No. We took out "to the extent possible."

CHAIRMAN ENTHOVEN: You took that out?

MEMBER DECKER: I actually think that's problematic because now it implies that everybody comes to the hearing. You need "to the extent possible." If they've been threatening everybody, I don't think they should have to have them at the hearing.

MEMBER SHAPIRO: They don't all have hearings either. I think you're creating a formality that doesn't exist, providing at least one opportunity to participate without stipulating what the form would be.

MEMBER LEE: Let's leave in "to the extent possible." The intent there is any of the provisions in law and other states say that if someone is abusive or threatening, there's exceptions to having them appear in person. That's what we noted as best practice. Some plans that have a standard practice, people can appear in person. They have other ways to even provide them to be there if not in the room. So we can, I

think, keep in "to the extent possible" -- would be fine. Okay.

MEMBER O'SULLIVAN: Could we take Michael's idea that -- the concern that there might not be a hearing so to participate one time rather than at a hearing.

MEMBER LEE: At least one time. Fine. Okay.

DEPUTY DIRECTOR SINGH: Is that clear for everybody?

Mr. Lee.

MEMBER LEE: "Plans should provide opportunities for members to participate in the grievance process in person at least at one time to the extent possible."

CHAIRMAN ENTHOVEN: Okay. All in favor?

DEPUTY DIRECTOR SINGH: Those opposed?

Twenty-two to one. The Recommendation is

adopted.

MEMBER LEE: Moving on to F. Cleanup language is after the parenthetical where it says "whether medical group or health plan," delete the word "both" and note "the physician should receive notice by phone or fax and the patient should receive written notice, both of which should include of the decision that was made" et cetera.

MEMBER SPURLOCK: Would you accept just

striking out "phone or fax" and just should be "notified"? I mean you could have "see in person."

MEMBER LEE: I think that's fine. I think that's quite friendly.

MEMBER SPURLOCK: It's not enforceable anyways.

MEMBER LEE: "The physician should be notified and the patient should receive written notice." I think that's fine.

CHAIRMAN ENTHOVEN: We don't want to rule out e-mail.

MEMBER LEE: We don't want to rule out e-mail, absolutely.

MEMBER SPURLOCK: Person to person.

DEPUTY DIRECTOR SINGH: Without objection.

MEMBER LEE: Move adoption.

(Multiple speakers.)

CHAIRMAN ENTHOVEN: What have we got here now?

MEMBER LEE: It reads, after the parenthetical, "The physician should be notified and the patient should receive written notice, both of which should include" -- delete the word "of" -- "the decision made" et cetera.

MEMBER ZATKIN: Peter, could you give

us an example of the types of additional information that potentially will alter the decision in the next review (inaudible)? There's a phrase that certain types of information is to be provided, namely, the types of additional information that potentially would alter the decision in the next review.

MEMBER LEE: Clinical studies or -- either clinicians of particular expertise, noting that this is alternative treatment available.

MEMBER ZATKIN: Why is that any different from expert opinion or guidelines (inaudible)? I'm trying to figure out what.

MEMBER HIEPLER: It's one you didn't have at the first hearing.

MEMBER LEE: It's basically telling the consumer this is what you need to provide. This is what you relied upon. If you want to counter it -- this is the sort of information you need to provide. It's trying to be -- speaking to the

consumer. Not to say this is what we did, but to go to the next step, to make an appeal, this is the sort of thing that you need to provide.

MEMBER ZATKIN: So we had these ten studies and we provide you with that. So -- and what would we then say to the consumer?

MEMBER FINBERG: You need your own study that disproves all ten of ours.

MEMBER GILBERT: From a practical viewpoint, are you talking about if it's a medical necessity (inaudible) referral to a specialist, what -- I mean you'd have to have a different medical condition to get that referral to the specialist. I've having trouble with Steve figuring out exactly what you mean by additional information that -- because we have to do that affirmatively is the way you're putting it. What I'm saying is if your knee was -- if you had a surgical knee, next time then you'll get surgery. I mean what do you mean by that?

MEMBER ZATKIN: All the things you could have had.

MEMBER DECKER: Peter, let me put this in a non-clinical situation because that's what I'm more used to dealing with. If our appeal process in our plan, one thing that can happen is a patient may have relied on information provided by the plan and it misled them about what their rights were.

If that was not part of the discussion and we hear it later, we will reverse the decision that was made. So it can be non-political information. It could be anything that you relied in making your decision.

MEMBER GILBERT: Barbara, how would the plan know what it was that hadn't happened that

they could tell the member that next time it would be reversed? See what I'm saying?

MEMBER DECKER: I understand what you're saying. Is there a way to say if applicable with this? Do we want a caveat in? Maybe it's something that --

CHAIRMAN ENTHOVEN: Bruce.

MEMBER SPURLOCK: Could I say something? It's a type of additional information. Under what circumstances that might change would alter the decision for further review. So that way, you know, it's circumstances rather than information.

I mean it's hard to put down guidelines or decisions for every single potential clinical and nonclinical thing and to say "This is what we tend to use to make our rules." But you might be able to say, you know, "If this changes or if this changes, we would look at this very differently. I think that actually, in fact, happens for many patients. The course of their clinical care

changes, and they do get into different situations.

MEMBER LEE: Well, I think there would be a way to say "and where applicable" the types -- and that is the sort of type: Your condition may change; it may be more advanced. And by adding the caveat "where applicable," it's noted that it's not going to be there every time. Would that be --

address the concerns and questions?

MEMBER GILBERT: It's kind of saying "When you're sicker, come back." And I just don't -- I think if you put "where applicable" then that obviously puts a modifier on it that the denier, if they have something in their head they know might change the decision, next time they can put it down. But from a practical point of view, you've got a fairly long list here that's going to make it fairly difficult as it is.

MEMBER SHAPIRO: I agree with that. Every decision on its own merits has a separate reason for why you may have been denied your request. People know exactly what it is. If you give them the reason -- I think that's what's critical about this -- they or whoever is advising them, including their physician, can conclude that. It's very hard to try and speculate. And I'll you the truth, plans don't want to do that, and I wouldn't expect them to volunteer. I think what's more important is that you give reasons for the

denial and support for that. You implicitly understand that if I can rebut that or come up with new information, that -- I think it's obvious; it doesn't need to be there.

CHAIRMAN ENTHOVEN: Could we just take that line out? Well, just appeal the decision,

period.

MEMBER FINBERG: Why don't we try it with "where applicable."

MEMBER LEE: Right. I think that "and where applicable the types of additional information that potentially develops (inaudible) next review."

MEMBER BOWNE: You know, the burden -- let me put it this way: There's no question that if there's a denial that the person needs to know why and where to go to next and what the denial is based on. But in all fairness, I don't think that it is incumbent upon the plan to hand the defense attorneys their entire case.

MEMBER ZATKIN: What about the plaintiff's attorney?

MEMBER BOWNE: The plaintiff's attorney, excuse me. I mean I would feel a lot -- I mean this is a lot. This is going a lot further because you're extending it to plans that don't do this now. And --

UNIDENTIFIED SPEAKER: (Inaudible.)

MEMBER BOWNE: Yeah. Right. All of a sudden he's woken up.

But this notion -- I would be much more comfortable if you could just strike this because I think it's fair that someone knows in a timely manner; they know on what the basis was made; they

know how to appeal. But this types of additional information to alter the decision, that could be anything and everything including -- it's just too broad.

MEMBER ZATKIN: That's the problem. I don't see it as a liability issue. I simply see it as sort of an endless potentially.

MEMBER LEE: I'd be okay with putting a period at "timing."

MEMBER BOWNE: Okay. Good. Good.

MEMBER LEE: If we could vote really quickly, and I could get some other votes later.

DEPUTY DIRECTOR SINGH: A period after "timing" and delete the remainder of that sentence; is that correct?

MEMBER BOWNE: Yes.

MEMBER LEE: Yes. We have a motion and a second to adopt this Recommendation as amended. Those in favor please say "Aye" -- or please raise your right hand. I'm getting tired.

Those opposed?

Twenty-five to zero. The Recommendation

is adopted.

Members, could I just let you know we have quite a few Recommendations left to vote on.

MEMBER LEE: We're zooming through them now. G, one amendment. Line three, "standard

(inaudible) to be used by health plans" and plug in the word for whatever we're calling the agency. So it's "and the agency that oversees managed care."

CHAIRMAN ENTHOVEN: This is on G?

MEMBER LEE: This is on G, Terminology and Data Collection.

The intent is that we want to have the Department or OHSO or whatever have the same terminology that it's collecting data on as do health plans. And so we're adding in "standard definitions to be used by health plans and the agency responsible for managed care oversite." The third line, period.

Any other amendments?

Move adoption.

MEMBER BOWNE: Second.

MEMBER LEE: All in favor.

DEPUTY DIRECTOR SINGH: Those in favor please raise your right hand.

Those opposed?

The motion has been adopted 23 to 0.

MEMBER LEE: No comments on H. And rather than vote on it, I'd like to lump it in with

the next one -- unless anyone has other changes -- so we don't have to do so many votes.

Moving to "I." The addition to "I" is on the very last line where it says "periodic basis," insert "This data should be reported with the

agency's own complaint or request for assistance data." The intent of that change is to make --

MEMBER SEVERONI: Say that again.

DEPUTY DIRECTOR SINGH: Can you read it again, Mr. Lee.

MEMBER HARTSHORN: Where are you?

MEMBER LEE: I'm at the -- on "I," the very last line where it says "plan specific (inaudible) data on a periodic basis."

MEMBER BOWNE: Wait. Is this before you get to all the dots?

MEMBER ZATKIN: Yes.

MEMBER LEE: The very last line of page 5. Last line of page 5. After it says "periodic basis" -- "periodic basis." To insert the sentence "This data should be reported with the agency's own complaint and request for assistance data." The intent is to have in one report from the agency as it gets the plan's complaint data, it releases it with its data that it's collecting. So there isn't so much data floating around, and we've now created common data as well.

Any other suggested changes on "I"?

Then I would suggest not putting this to a vote until we then go to J and vote on --

(Multiple speakers.)

MEMBER LEE: I'm not trying to move off

it; I'm trying (inaudible) some other changes. But I do have others.

So other suggested comments or changes on "I"?

DEPUTY DIRECTOR SINGH: Please note that "I" continues to page 6.

MEMBER LEE: Yes, with a number of bullets, which are listed as four example bullets, not as directive, which would be developed in this collaborative process.

CHAIRMAN ENTHOVEN: I was going to ask, do we have to have this sorted by plan and medical group, IPA per groups? Do we have to do all the sorting?

MEMBER BOWNE: It's getting awfully prescriptive and detailed.

MEMBER DECKER: It's only a recommendation of what the agency should consider to be included. It's not saying "do this." It's just giving ideas.

MEMBER BOWNE: But the fact that it's there and in such detail -- this is extremely cumbersome and burdensome to come up with all this information and to slice it all these ways.

MEMBER WILLIAMS: Could we end it after "or type of complaints"? It says "aggregate numbers" -- there's something more --

MEMBER LEE: Ron is suggesting in the

first bullet to end it after where it says "type of complaint." Now, we originally recommended that this be done, but this is now a list of examples of things to look at. The intent is that consumers will often want to know for large medical groups as much about the medical group as the health plan. And to stop it off there, we're raising this for discussion. This is not law. This is saying that plans and the stakeholders should talk about what is the best way to collect and report this in a way that is effective and not too costly and credible.

I mean I think it's important to remember that over some threshold it's -- medical groups are huge. And having complaint data that relates to them is important. That was the intent there.

MEMBER ZATKIN: How about if we say what you just said to the extent that it's not too costly and credible in terms of -- these items would be considered on the basis -- on that basis.

MEMBER LEE: Great. I think that's fine. To add a bullet that says the -- "considered in the collection of reporting of data should be the cost, credibility and validity of the data."

CHAIRMAN ENTHOVEN: Where do you put

that?

MEMBER LEE: That's the first bullet -- oh, no the last bullet. Coming after all the

others. It will be a fourth bullet.

CHAIRMAN ENTHOVEN: "Consider cost" --

MEMBER LEE: "Cost" -- it's really saying "cost, comparability and validity."

MEMBER HARTSHORN: Peter, I think there's some issues --

MEMBER LEE: Terry and then Brad.

MEMBER HARTSHORN: -- depending on how the data would be sliced and provided and what data peer review confidentiality -- in other words, there are certain protections for the providers under that. So can we add some wording that says as long as it doesn't violate peer review --

MEMBER LEE: Absolutely. And I'd add that with a semicolon after validity "and no such reports should in any way impinge upon confidentiality or peer review."

MEMBER WILLIAMS: The second and third bullets I have some difficulty with, some of them from a logistics point of view. A summary of the recent decisions were upheld or overturned. If you don't have some standard definition around the types of reasons, that could result in very large narratives. Because each grievance is different.

MEMBER LEE: The assumption is that

there needs to be common terminology which goes back to Recommendation G for terminology. The desire here is not to have each decision, but to

say "Here's the five reasons: Not medically necessary; not part of the plan documents; not fully supported, whatever. It is to have it in typology and not have specific decisions.

MEMBER GILBERT: Just remember, though, then you'll have typologies for the grievances, and then you'll have typologies for the reasons of which there will be multiple typologies for each grievance. Because within a category of a grievance, there could be five, ten different ways to resolve it.

On the third bullet, basically you're asking for our grievance process and our QI Plan, both of which are already submitted to the DOC and, in our case, DHS for approval. That's -- the third bullet is a description of the process by which complaints were handled -- that's our grievance process -- and the analysis of those complaints and how to find use of the information. That's our QI Plan.

MEMBER FINBERG: He's just saying it should be in the report also. What you submit to the DOC should also be duplicated to the public.

MEMBER GILBERT: These are documents that are inches thick in terms of what the -- you

know, the complexity of how the plan uses information from grievances for quality improvement

is pretty substantial. That's my only point. To try to tie it to a report related to specific grievances, I don't know how useful that is.

DEPUTY DIRECTOR SINGH: Is there further discussion?

CHAIRMAN ENTHOVEN: Yeah.

Peter, you said you'd put "consider cost, comparability and validity as long as it doesn't violate confidentiality of peer review."

MEMBER LEE: They're separate points.

MEMBER BOWNE: Those are separate things.

CHAIRMAN ENTHOVEN: Doesn't that apply to the whole thing, though?

MEMBER LEE: Pardon me?

CHAIRMAN ENTHOVEN: Doesn't that apply to all of those?

MEMBER LEE: Yes. But it's not validity; it's a confidentiality issue.

CHAIRMAN ENTHOVEN: The question is whether -- I hope we've got it close enough here.

DEPUTY DIRECTOR SINGH: Is there a motion to adopt Recommendations H, I -- H and I?

MEMBER WILLIAMS: We never talked about H. It got lumped in with "I."

MEMBER LEE: I asked the question if

there were amendments to it.

MEMBER WILLIAMS: Okay. Well, I guess

the question -- I'm not sure what it means on the basis of it -- what is it that people would have to do? What is it the health plan has to do?

MEMBER LEE: What this would be is to try -- is if there are -- like, for instance, in Sacramento, there is an independent program that's an external resource. We'll talk later about external resources. This would be that plans would provide notice that consumers have other resources available to them. They do that now for high cap for Medicare beneficiaries.

CHAIRMAN ENTHOVEN: Does the plan have to research every lawyer's office in town and ask them whether they're a resource available to help?

MEMBER LEE: I would not think so.

MEMBER BOWNE: For instance, is this something they have to have printed on the back of every card? Do they have to mail it out every month? Can they put it in a newsletter?

MEMBER LEE: Rebecca, if you'd like to add additional details to these recommendations, you could do that certainly.

MEMBER BOWNE: I think what Ron's asking and I'm suggesting is that one of the problems is is that it's well intentioned, and I agree with that. But then all of a sudden the

health plan gets a big fine from SOSO or whatever

the new company is because they didn't (inaudible).

(Multiple speakers.)

MEMBER BOWNE: And that's what I'm worried about.

MEMBER LEE: Well, I think throughout these recommendations and the very first one which we adopted and sort of swept over is the actual details on these would be developed in collaboration. And I know that usually these at the table isn't consumer groups as much as we've talked about it in terms of these being developed. And the "OHNO," as it may be called, as well as "SOSO," what it does in terms of doing the follow up on this is going to be the subject of being fleshed out significantly. The intent is I think it's important for the Task Force to say that people should know there's external resources they can turn to.

MEMBER SHAPIRO: Peter, you might want to move it to your external resource because that provision describes what you're talking about, the types of entities. Some people ask what you mean by this. You may want to just fold it into the Recommendation on General Resource because you mentioned that you've got (inaudible) and you've the Health Rights hotline. And I think there's a better understanding of what you mean if you put it

in the context of that later provision.

MEMBER DECKER: While we're moving it, I'll mention that we've done an hour.

CHAIRMAN ENTHOVEN: What are we doing to this?

MEMBER LEE: I mean I'm happy with moving it to -- fine with moving it to No. 7 to be included in the discussion of 7. But it still needs to be discussed there, though.

MEMBER FARBER: A logical place to put something like that is when health plans disclose to their clients what their grievance process is, then it's just logical to place that in the body of that document. And it doesn't have to result in a punitive thing like Rebecca's concerned about. I mean if you just say that that's where health plans are going to put this information, and then, you know, you can also reference the "OHNO," OHSO or whatever it is -- "SOSO" thing we're going to do and say that further information about assistance external to the plan can be accessed by calling OHSO's number.

But I think -- it's meant as a general advisory. It's not meant to be something punitive for the health plan. It's just to tell people that, you know, their last court of appeal isn't the final grievance step in their health plan.

CHAIRMAN ENTHOVEN: But the open end of

this is kind of the problem. If you'd said "officially certified" or something so you just define the universe with some precision.

MEMBER FARBER: I think a logical place is just put it in your grievance procedure.

MEMBER LEE: I think the concern is is that qualifier of the external assistance is what I'm hearing. Well, there's two concerns: One is where does it go; the other is what do we mean by "external assistance"? You could say "official external assistance"? Would that help?

MEMBER DECKER: "Official"?

MEMBER LEE: Yeah. It's -- no? Okay.

MEMBER FARBER: I think what you're trying to do is to tell people that your health plan is accountable to a state agency. And the state agency's is XYZ.

MEMBER DECKER: No. This is different.

MEMBER LEE: No. That's already there.

(Multiple speakers.)

MEMBER BOWNE: If that would be it, that would be just fine. What it is is that this puts a burden on the health plan to know all the rights groups, if you will. And let's take a statewide plan; okay? So that means in their grievance procedure, they'd have to modify it for each particular area because Peter's group's in Sacramento and Tom's group's in, you know,

Los Angeles.

MEMBER FARBER: Why don't you consider then, Peter, modifying the language to say that, you know, information, but where external assistance can come from can be accessed at OHSO. Does that meet your general need?

MEMBER DECKER: No. I think we really should put this in the other item because that's where we talk about it. Let's just move it over--

MEMBER LEE: Let's carry it over to there.

DEPUTY DIRECTOR SINGH: Without objection, we'll move H to No. 7.

Do we have a motion to adopt Recommendation No. I please.

MEMBER DECKER: So moved.

MEMBER LEE: Second.

MEMBER GILBERT: Can we get rid of the third bullet?

MEMBER HARTSHORN: I'll bring up my level-playing-field argument again. We're going to have data that's going to look at health plans, and there's a lot of fee-for-service providers that have complaints, too. Should they be required -- I mean I think they should --

MEMBER LEE: Yes.

MEMBER HARTSHORN: -- be required to sort their complaints to their appropriate

agencies.

MEMBER LEE: I would strongly support --

MEMBER HARTSHORN: (Inaudible.)

MEMBER LEE: -- that this Recommendation for both the terminology and data collection -- this is where it says above the state agencies for regulation of managed care. Part of the intent in G is that it's not a sole-agency issue in terms of currently it's a DOC and a DOI issue. It should be the range of health providers.

MEMBER HARTSHORN: Or a Board of Medical Examiners issue with individual physician complaints filing.

MEMBER LEE: We have not reached the issue of having common terminology and data collection at the individual level as opposed to the systems of care.

MEMBER HARTSHORN: But it starts with the individual level and goes up to systems of care. I mean the system can do it by the system. But it still starts down at the physician contact level.

EXECUTIVE DIRECTOR ROMERO: Would a compromise be in the third line of G, replace the word "plans" with "insurers"?

MEMBER DECKER: "Insurers" is more limiting.

EXECUTIVE DIRECTOR ROMERO: My sense is you want to extend this Knox-Keene Plan.

MEMBER LEE: I mean the intent in health care is not to limit it to Knox-Keene-licensed Plans.

DEPUTY DIRECTOR SINGH: We've defined "health plans" in this Paper and in Papers generally to mean Knox-Keene-regulated health plans and carriers unless we specifically say otherwise. Generally health plans --

MEMBER LEE: That's certainly is the intent. I think that we do need some sort of public reports. We, again, I think say that this data should include data on all health plans. Insert that in as a sentence after the first sentence.

MEMBER DECKER: In "I"?

MEMBER LEE: Yes.

MEMBER DECKER: It actually should be several sentences down. "Data reported to the state agencies" --

MEMBER LEE: Right.

MEMBER DECKER: The last complete sentence or last sentence starting on 5.

MEMBER LEE: "Data reported to state agencies should include data on all health plans" --

MEMBER SCHLAEGEL: "For regulating."

DEPUTY DIRECTOR SINGH: Without objection?

MEMBER GILBERT: Which one? The whole thing or --

MEMBER LEE: Yes, the whole "I."

MEMBER GILBERT: I still think --

DEPUTY DIRECTOR SINGH: Just on "I." Members, are we ready to vote on "I"?

CHAIRMAN ENTHOVEN: I think Peter needs to read it.

MEMBER LEE: Okay. What we have is -- what we have just inserted is "Data reporting" --

(Multiple speakers.)

MEMBER SCHLAEGEL: Public reports. All the way at the end.

MEMBER LEE: We haven't changed the first eight lines. Okay. "Currently Knox-Keene Plans must report complaints pending longer than 30 days (inaudible) resolution, analyzing complaints and using the information for quality improvement. In addition, after standard (inaudible) terminology has been aggrieved, see Recommendation 3-G above, the state's agency (inaudible) regulate the managed care should developed in collaboration with stakeholders and implement additional public reporting requirements (inaudible) and if necessary data reported to the state's agencies for regulating managed care should be reliable and

comparable, and the state's agencies through regulating managed care should publish plan-specific and aggregate data on a periodic basis that should include data on all health plans. This data should be reported with the agencies own complaint and request for assistance data in determining the amount and nature of information," et cetera, et cetera. And then we added a new bullet, which I think someone up at the head of the table got down the verbiage for.

CHAIRMAN ENTHOVEN: Consider cost, comparability and validity as long as it doesn't violate confidentiality or peer review.

MEMBER BOWNE: No, no.

(Multiple speakers.)

MEMBER FINBERG: "Confidentiality and peer review will be maintained".

MEMBER LEE: Right. Let's do it as a separate bullet.

(Multiple speakers.)

MEMBER LEE: Brad, did you have a --

MEMBER GILBERT: I would really -- the third bullet I would have -- if the group is willing, I'd really like to get removed. Because if we're listing things, our lists are going to be taken as things to do. And that third bullet would be very burdensome.

DEPUTY DIRECTOR SINGH: Is there

objection to remove the third bullet? The existing third bullet.

MEMBER FARBER: Delete?

DEPUTY DIRECTOR SINGH: Seeing no objection, Members, we have a motion on the floor to adopt Recommendation I as amended. It's been second.

Those in favor of adopting Recommendation I please raise your right hand.

Those opposed?

Recommendation has been adopted 22 to 0.

MEMBER LEE: J is to change the introduction to facilitate consumer -- contact of consumers to regulators. Delete the entire first sentence (inaudible) "in addition." It's redundant to what we say before. And instead say "The agencies responsible for managed care oversite should provide a single statewide 800 number that seamlessly transfers the consumer to the appropriate agency." The intent here is we currently have DOC and DOI -- many people don't know either of the numbers, but -- let alone that problem, and having one number would certainly make things simpler.

Move adoption.

UNIDENTIFIED SPEAKER: Second.

CHAIRMAN ENTHOVEN: "The agencies" --

MEMBER FINBERG: Could you read the

beginning again.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: It's been moved by Mr. Lee. Seconded by --

MEMBER FINBERG: I just want him to read it. "To facilitate" --

MEMBER LEE: "Contact the consumers to regulators. The agencies responsible for managed care oversite," plural "agencies," et cetera. So move, seconded.

DEPUTY DIRECTOR SINGH: Who has it been seconded by?

MEMBER FINBERG: Me.

CHAIRMAN ENTHOVEN: Maybe it doesn't matter, but I just don't understand what you're doing here.

MEMBER LEE: Having one phone number --

CHAIRMAN ENTHOVEN: This is No. J; right?

MEMBER LEE: This is No. J. We're having one phone number. That's so you can promote if you're a consumer and you've got health-care concern and you want to talk a state regulator, there's one place you can call.

MEMBER FARBER: It's been moved and seconded.

MEMBER LEE: Yes.

MEMBER FARBER: Can you call the

question?

MEMBER LEE: All in favor.

MEMBER FARBER: Let's call the question.

CHAIRMAN ENTHOVEN: No, no.

MEMBER LEE: We're just voting.

DEPUTY DIRECTOR SINGH: All right.

CHAIRMAN ENTHOVEN: I think you need to read the new language starting with J, clear oversite -- government oversite --

MEMBER LEE: No, that was all deleted.

CHAIRMAN ENTHOVEN: You deleted that.

MEMBER LEE: Yes. It was all deleted all the way through "the agencies."

DEPUTY DIRECTOR SINGH: Then it starts "The agencies responsible for regulating managed care should provide a single statewide 800 number that seamlessly transfers consumers to the appropriate agencies.

CHAIRMAN ENTHOVEN: Right.

DEPUTY DIRECTOR SINGH: It's been moved, and it's been seconded.

Those in favor of adopting this Recommendation please raise your right hand.

Those opposed?

Twenty-one to zero. The Recommendation has been adopted.

MEMBER LEE: Okay. Four.

MEMBER SEVERONI: Peter, if I may just before you move on, in Item I, I just wanted to ask again the Executive Director, in Item I here, we referenced the group stakeholders. And throughout our Papers at different times we've identified what that group is. And most of the time we say that includes consumers.

MEMBER LEE: Ellen, were you here at the morning -- well, there will be an introductory footnote that defines stakeholders.

MEMBER SEVERONI: Okay. Thank you.

DEPUTY DIRECTOR SINGH: In our glossary of terms.

MEMBER BOWNE: To include consumer groups; is that correct? To include consumer groups.

DEPUTY DIRECTOR SINGH: Mr. Lee, would you please --

MEMBER LEE: Move along. 4-A, B and C, no technical amendments to.

MEMBER RODRIGUEZ-TRIAS: Thank you.

MEMBER LEE: Anyone else have technical amendments to?

DEPUTY DIRECTOR SINGH: For A, B and C?

Seeing none, is there a motion to adopt --

MEMBER LEE: Terry has a comment or

question.

DEPUTY DIRECTOR SINGH: I'm sorry.

MEMBER HARTSHORN: Are we on -- are we talking about the -- all kinds of required (inaudible)?

DEPUTY DIRECTOR SINGH: Could you please speak into -- I'm sorry, I can't hear you.

MEMBER LEE: Yes.

MEMBER HARTSHORN: If there's no indicated --

MEMBER LEE: Yes. Yes, we are talking about C as well.

MEMBER HARTSHORN: I think the use of the word "independent" is a little hard to follow. Are they -- if they're in the qualified network, does that really make them independent? I was just recommending that we strike "independent" if there's no qualified networking provided.

DEPUTY DIRECTOR SINGH: Is there objection to strike the word "independent" on page 7 in the second line in C?

MEMBER FINBERG: I think it means that it's independent of the first clause. So that would be (inaudible).

MEMBER FARBER: What if it's this guy's boss, you know?

DEPUTY DIRECTOR SINGH: Could we just have a quick straw poll vote not to -- never mind.

We're not going to delete "independent"?

MEMBER FARBER: It's being discussed.

DEPUTY DIRECTOR SINGH: Okay. Mr. Lee, could you --

MEMBER LEE: Is there another way to clarify this? I mean the intent is that there should be some independence when you get a second opinion. And so --

MEMBER HARTSHORN: As long as independence doesn't mean it has to be someone outside of the network.

MEMBER LEE: No. And that's not the intent.

MEMBER HARTSHORN: How do we clarify that? That's all I'm after.

MEMBER LEE: By welcome wording suggestions.

CHAIRMAN ENTHOVEN: Qualify (inaudible) --

MEMBER HARTSHORN: You want to say it's a different provider rather than independent. All we want is a second opinion from another physician.

MEMBER FARBER: Yeah. But it doesn't work out if the second opinion comes from the-- you know, the same IPA as this guy's boss or something.

MEMBER LEE: How about if we say if

there's no separate qualified network provider?

And "separate" provides the communication that it's not -- there's a distance there without saying "independent"? Is that friendly, Terry.

MEMBER HARTSHORN: Okay.

DEPUTY DIRECTOR SINGH: Without objection?

MEMBER LEE: Great. So move--

MEMBER SHAPIRO: Peter, I've got a quick question.

MEMBER LEE: Yeah.

MR. SHAPIRO: On B on page 6, it is a question. The last line says that "When the decision of the medical group/IPA differs from the physician, the patient should be given oral notice or written notice on request." Has that been the practice now if your physician has recommended treatment and it's reversed by the IPA or someone else, you only know that if you've asked for it on request?

DEPUTY DIRECTOR SINGH: No.

MEMBER LEE: No, no. They were given oral notice. The distinction is that -- they would always be given oral notice. The written notice they would need to request.

MEMBER SHAPIRO: Okay. Could we put a comma after "oral notice"?

MEMBER LEE: I think that's friendly.

28 We have inserted a comma.

MEMBER ZAREMBERG: Somebody explain how C is different from existing practice. What do you do when there's no qualified in plan, a provider? What happens.

MEMBER HIEPLER: You get the denial.

DEPUTY DIRECTOR SINGH: Mr. Lee, are you able to --

MEMBER WILLIAMS: I think if it's a matter of actually accessing care, at least in our PPO, there is an actual process that the member can go through the request in an ability to see a non-network provider and be kept whole financially so they may have both access and financial insulation in terms of access to care.

MEMBER ZAREMBERG: I'm just trying to figure out how this is different than existing practice. Is it different than existing practice, or is it the same?

MEMBER DECKER: I think currently in some health plans the second opinion is only within the same designated medical group that you're enrolled in. We're trying to say that you can go outside of your medical group.

MEMBER ZAREMBERG: I thought somebody said only if there's nobody qualified inside the medical group?

MEMBER LEE: That's under the notion of separateness. It needs to be within plan. There's

no mandate to go out of plan or to be able to go out of plan unless there's no one qualified there.

MEMBER DECKER: So the words -- I don't know where "separate" is.

MEMBER LEE: Separate took the place of "independence."

DEPUTY DIRECTOR SINGH: The word "independent" was deleted, and we used "separate" to substitute.

MEMBER ZAREMBERG: So you can go outside the plan if there's no one qualified inside the plan.

MEMBER FARBER: But now is independent of the person that gave the first decision.

CHAIRMAN ENTHOVEN: Not in the same medical group.

MEMBER FARBER: Not in the line of authority. It would be awfully hard for one guy to go over his boss.

MEMBER ZATKIN: That's why we have the external review discussion coming up, I believe.

MEMBER LEE: We're getting too involved in this.

MEMBER ZATKIN: The second opinion is a step, and external review is the next step.

MEMBER DECKER: I think one of the

challenges here is we're not just talking about HMOs. We're talking about multiple kinds of plans. Do we need to be clear, Peter?

MEMBER LEE: I think the whole point is that "health plans" means all health plans throughout, and we are not --

MEMBER DECKER: But I'm talking about the network versus the out-of-network. Does that mean within the plan and out of the plan? I don't think it does.

MEMBER LEE: No.

MEMBER DECKER: But I think some people are taking it that way.

MEMBER ZATKIN: It's within.

MEMBER DECKER: Okay. If this was an HMO, I think the intent is it's outside the medical group.

MEMBER FARBER: It could be outside of pod of working -- you know, some medical groups are composed of several pods, and it could be an opinion from a separate pod.

DEPUTY DIRECTOR SINGH: Dr. Spurlock.

MEMBER SPURLOCK: I think what we're trying to do is we're trying to say the patient should have an option and choices on second opinions. I think the first and the fastest of any second opinion that will happen most likely -- and

that medical group's going to have no problems with it because it's happening all the time now -- is within the medical group. And that happens

frequently that people get second opinions within an individual medical group.

I think the issue becomes when you go outside of the medical group for a second opinion, the language says that you have to be required to pay for them from the health plan standpoint.

The third issue, which I think Steve alluded to, was the independent external review. I think we haven't gotten there yet. So what I would say is that we need to have some language in here that talks about offering patients the choice in the medical group first because it often happens fast or it's already going on, and it should be the first recourse. And if the patients want that, great. If they want to go outside the medical group, then we have to have the health plan paying for it, a second opinion, in that situation.

MEMBER ZATKIN: But Nancy's point about -- isn't there some line even within current practice in terms of who's normally involved in the second opinion?

MEMBER SPURLOCK: No. It's hard to imagine every single clinical situation for every clinical disease and how much expertise somebody has within the group. There may be conditions

where a pulmonologist who's a specialist, who's done research in certain areas, that's an expert, people send that person to. But on some other

pulmonary instances they want to go out of the medical group or, you know, out of the existing network. I think those situations have to happen.

But I think should be an option to stay within the medical group if that's possible because it doesn't cost anything and there's lots of mechanisms for that to happen already. It's only when you go outside the medical group that we have to have methods to pay for that from the health plans.

MEMBER FARBER: I just want to clarify my point. I don't have any trouble with large groups like Kaiser. There are enough specialists within that organization so that you can get somebody out of the direct line of -- chain of command. It's in smaller groups where it gets to be a problem where everybody's in each other's pocket, and you want to reinforce what your practicing partner says. That's no kind of second opinion at all for a patient to get.

So I think some of this is size driven. But I think that patients should be assured that when they get a second opinion, that there isn't that built-in conflict there.

DEPUTY DIRECTOR SINGH: Dr. Northway.

MEMBER NORTHWAY: I think one of the areas where you want to make sure that you can go out of plan has to deal with vulnerable population,

but particularly children, where, in fact, there may not be anybody else in the group. And I think if Barry Cristy was here, he would have said he didn't want another opinion from another urologist in the group that he'd already been to. The issue was there wasn't anybody there. The group did not agree to that. They just said "No."

So I think the issue regarding vulnerable population, particularly children, you have to have some kind of a way in which the family can make sure that somebody who is an expert in pediatric care has a chance to see their child.

MEMBER ZATKIN: That's the external review.

MEMBER NORTHWAY: Yeah.

MEMBER LEE: It is also a second opinion. The point about second opinion, the language that I think is most important here is not so much that it's both separate, but it's also the qualifying. It's that some of the concerns that come up is they got a second opinion, but just because it's the doc next door -- the issue isn't that it's next door, but is the doc a pediatric oncologist or whatever.

So the intent of the language is separate and qualified. And -- well, anyhow, that's --

MR. SHAPIRO: Let me just add, because I suggested the qualifications last time, this

language reflects best practice; that every health plan filed with the Department of Corporations its second opinion procedures. And most of them but not all of them simply said "You first come to us. And if we have" -- an they used "independent" or "separate," but it dealt with this concern -- "qualified person, you have to do it in plan. If you make a case that we don't have that separate qualified person, we'll pay for it out of plan."

So this is the general policy of most plans that have submitted their positions to the Department of Corporations. And the only thing we changed from the earlier one was there are some exceptional cases where you want to go out of the plan, and that deals with when they don't have a qualified person who, whether it's independent or separate or whatever it is, is not considered the right person.

But in 95 percent of the cases, you're in plan; you're in medical group, and you don't want to wait for the independent review. You want to resolve it at this point.

MEMBER LEE: I'd like to move adoption

on the "separate qualified" as it stands.

MEMBER BOWNE: Second.

MEMBER ZAREMBERG: This is the same as existing practice.

MR. SHAPIRO: Yes.

MEMBER FARBER: Yeah. For the most part.

MEMBER LEE: For the most part for many plans, existing practice.

CHAIRMAN ENTHOVEN: Because there's some who don't do it is what you're saying.

MEMBER ZAREMBERG: When they file it with the DOC, does the DOC not go back and have the plans that don't comply comply with what they're doing.

MR. SHAPIRO: No, because the legislation that got through said the DOC is not authorized to approve or disapprove any of these filings. That was a qualification put in there. They file it in hopes that it would encourage people to do best practices. But, in fact, it's not uniformly done. And the DOC is explicitly prevented from making them do it.

DEPUTY DIRECTOR SINGH: Without further discussion, those in favor of adopting Recommendation 4-A, B and C please raise your right hand.

Those opposed? Twenty-two to zero. The

Recommendation is adopted.

MEMBER LEE: Five, no technical amendments.

Any comments or suggestions?

DEPUTY DIRECTOR SINGH: The comment is

we've used up all the time that was allotted.

MEMBER LEE: Okay. I just move we pass all the rest and move on to the next one.

DEPUTY DIRECTOR SINGH: Is there a motion to adopt Recommendation 5 as originally proposed?

MEMBER SEVERONI: I'll move it.

MEMBER BOWNE: Second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation 5 please raise your right hand.

Those opposed.

The recommendation is adopted 23 to 0.

MEMBER LEE: No technical amendments to 6-A and B.

Any suggestions or additions?

Move adoption.

MEMBER BOWNE: Second.

DEPUTY DIRECTOR SINGH: I'm sorry, who seconded. Thank you.

Those in favor of adopting Recommendation 6-A and B please raise your right

hand.

Those opposed?

The Recommendation is adopted 26 to 0.

MEMBER LEE: Seven, there is one technical amendment which is the very last line of the Recommendation 7 at the top of page 8. It says

"Common data collection and evaluation systems," and somehow in the conversion from the prior draft we did a straw poll and we neglected -- we left off "and publicly shared data regarding complaints to identify systemic problems."

MEMBER FARBER: I don't know where you are.

MEMBER LEE: I'm at the top of page 8. "The pilot programs should have common data collection and evaluation systems and publicly shared data regarding complaints to identify systemic problems."

CHAIRMAN ENTHOVEN: "Publicly shared" --

MEMBER LEE: "Data to identify systemic problems."

DEPUTY DIRECTOR SINGH: Any further discussion?

Ms. Finberg.

MEMBER FINBERG: Yes. I'm convinced that we need a statewide external ombudsperson. That the exact details of that program could be up

to debate and the timing and funding could be up to debate, but not the fact that we need something statewide. So I would suggest that we add a sentence at the beginning of this Recommendation to indicate that we recommend an independent external assistance or external ombuds program that would be

statewide. And then we could go on to recommend that the first step towards implementing that program be this, the two pilot projects.

DEPUTY DIRECTOR SINGH: Ms. O'Sullivan.

MEMBER O'SULLIVAN: I want to recommend an amendment --

DEPUTY DIRECTOR SINGH: Could you speak into the mike. I'm sorry.

MEMBER O'SULLIVAN: Sorry.

UNIDENTIFIED SPEAKER: Maryann, could you speak to Jeanne's point first?

MEMBER O'SULLIVAN: Sure.

UNIDENTIFIED SPEAKER: Can we kind of deal with that?

DEPUTY DIRECTOR SINGH: Is there any further discussion on Ms. Finberg's point? Is there any objection to including this as an amendment.

MEMBER DECKER: I object to it. I think we need the results from the pilots before we

make the statement that we know we need a statewide ombudsman program.

MEMBER HARTSHORN: Yeah, I would agree with that. I mean we may find out it's more -- it's better to do regional programs. Because, you know, we know health care is different in different parts of the state. We may need to personalize it

or (inaudible). I'd wait until the pilots are done.

DEPUTY DIRECTOR SINGH: Could we just have a very quick straw poll vote on that? Those in favor of Ms. Finberg's amendment.

MEMBER FINBERG: Let me just make one comment, which is what I'm suggesting would not preclude local implementation. In fact, I'm in favor of local control of the program. What I'm suggesting is that we need a resource statewide.

CHAIRMAN ENTHOVEN: Could you just tell us what the words would be again.

MEMBER FINBERG: Okay. "The Task Force recommends that" -- I guess -- well, "the Governor and Legislature authorize an independent external assistance or ombuds program throughout the state" as a first step, and then we go on.

MEMBER GRIFFITHS: Question.

CHAIRMAN ENTHOVEN: All in favor of --

DEPUTY DIRECTOR SINGH: We had one quick question.

MEMBER GRIFFITHS: I'm not clear whether what we would actually be proposing here is simply that that's a statement of intent, that ultimately we'd want to move there, and the pilot program is a way to get there or whether we're actually proposing this statewide ombudsperson program as well as the pilot program.

MEMBER LEE: I think Jeanne's intent was that the first steps of such an effort would be to fund two pilot projects.

MEMBER FINBERG: That's right. I'd like us to declare that we want something statewide. We're not prepared at this point to recommend or implement the details statewide, but we're willing to say that that's important and that we recommend it. In order to implement that recommendation, we're going to first authorize these two particular pilot programs.

MEMBER GRIFFITHS: Thank you.

CHAIRMAN ENTHOVEN: Okay.

DEPUTY DIRECTOR SINGH: Could we just take a quick straw poll vote on Ms. Finberg's recommended amendments since we had objection?

Those in favor please raise your right hand. This is a straw poll vote, Members.

Those opposed?

There were more in opposition than in

support of this, so it was just a straw poll vote. That recommendation will not be included.

MEMBER LEE: Any other recommendations, changes to what's here?

MEMBER O'SULLIVAN: I had one on F, page 7, the second-to-the-last line, that we delete the word "and" and after "advising" say "and advocating on behalf of consumers."

MEMBER BOWNE: Before you get to No. 7?

MEMBER O'SULLIVAN: Uh-huh. F. That paragraph under F, second-to-the-last line. So I want to add one of the things that this external review entity would do: It would advocate on behalf of consumers.

DEPUTY DIRECTOR SINGH: I'm sorry, Ms. O'Sullivan, what is the amendment you're proposing?

MEMBER O'SULLIVAN: The second-to-the-last line, after "counseling," I'd put a comma, delete "and." After -- keep "advising." And then add -- insert "and advocating on behalf of consumers." So it would read -- you know, it would "provide," dah, dah, dah "counseling, advising and advocating on behalf of consumers."

MEMBER SPURLOCK: Could you tell me the difference.

UNIDENTIFIED SPEAKER: What happened to "(inaudible) problem resolution"?

DEPUTY DIRECTOR SINGH: Would that continue?

MEMBER O'SULLIVAN: Yeah.

DEPUTY DIRECTOR SINGH: So the sentence would then read "appropriate activities performed by external resources may include developing and

distributing educational material, providing referrals to existing resources, counseling, advising and advocating on behalf of consumers on problem resolution at every stage in the process."

MEMBER O'SULLIVAN: Yeah, but I goofed, because it should be "advising on problem resolution" and then "and advocating on behalf of consumers." Sorry.

MEMBER ZATKIN: You're talking about external lobbying?

MEMBER O'SULLIVAN: No. That's not what I meant. I was thinking of just advocating--representing the consumer at each stage of the process.

MEMBER ZAREMBERG: Would that be legal to represent patients?

MEMBER ZATKIN: Then you would put it in --

MEMBER ZAREMBERG: You have legal

representation.

MEMBER O'SULLIVAN: That's open.

MEMBER ZAREMBERG: Before I vote on it, I'd like to know what it means -- what your intent is.

MEMBER O'SULLIVAN: Of course, I would like it to be advocacy in and outside of the courts. But if that can't move, then I would be happy for it to be advocacy not as far as

(inaudible).

DEPUTY DIRECTOR SINGH: Dr. Spurlock, did you have a comment?

MEMBER SPURLOCK: That was question. Are we talking about advocacy in the courts or out?

MEMBER RODGERS: Are you talking about legal counsel or (inaudible) --

DEPUTY DIRECTOR SINGH: Perhaps it needs to be clarified.

MEMBER O'SULLIVAN: Why don't we do it as two different things. Why don't we say advocacy and legal counsel in court matters or --

MEMBER BOWNE: You lost us all now.

MEMBER ZATKIN: Isn't that a separate --

MEMBER LEE: It's separate from what most ombuds-type programs do, how far they go with legal. I think that one of the things that this

may include is if it would be a friendly amendment to this to note "and advising and assisting consumers with consumer problem resolution at every stage." Would that be meeting you halfway?

MEMBER O'SULLIVAN: Uh-huh. Yes.

MEMBER LEE: "And advising and assisting consumers with problem resolution at every stage." Would that be acceptable?

DEPUTY DIRECTOR SINGH: Is there any

objection to that amendment?

MEMBER WILLIAMS: How does it answer Allan's question relative to your comment?

MEMBER LEE: It pulls out the advocacy legal implications entirely is how it addresses Allan's concern.

DEPUTY DIRECTOR SINGH: Does that address your concern, Mr. Zaremberg?

MEMBER ZAREMBERG: Well, I think it does. I think in Peter's mind -- I don't if the language does, but I think in Peter's mind it probably does.

MEMBER LEE: What's that worth?

MEMBER HIEPLER: Guess what he's thinking right now.

DEPUTY DIRECTOR SINGH: Members. Mr. Rodgers.

MEMBER LEE: I'll testify as to my

intent.

MEMBER ZAREMBERG: The language doesn't always reflect some of these amendments.

MEMBER LEE: I know.

MEMBER RODGERS: One of the difficulties when you combine the legal and advocacy is that for an attorney or somebody doing a case finding. And it really puts the ombuds program to be suspect. That really what they're trying to dig up is legal issues for attorneys so

they can go to court. You really do want to separate that. And I've talked to a number of advocates, and they agree that that process really appraisal should be separate.

So we don't want to assume there's a legal representation here, but rather that person is being advocated for and being advised on how to resolve their grievance.

DEPUTY DIRECTOR SINGH: Is there further discussion?

CHAIRMAN ENTHOVEN: How do we reflect that in words?

DEPUTY DIRECTOR SINGH: Have we not done that with the second OHSO Amendment?

CHAIRMAN ENTHOVEN: Assisting consumers?

MEMBER HIEPLER: How about after "existing," you might put "informal resources

counseling." I mean that might take care of that.

CHAIRMAN ENTHOVEN: Yeah, yeah.

MEMBER HIEPLER: Just leaves the word "informal" --

DEPUTY DIRECTOR SINGH: I'm sorry, "existing" and then ad the word "informal" --

MEMBER HIEPLER: Yeah. "To existing informal resources" and then you list the types.

MEMBER LEE: No. The provider referrals to existing resources is -- may actually

include in a lot of -- pretty much all ombuds (inaudible) may refer to formal resources like the Department of Corporations is a formal resource. So I would not consider that amendment a friendly amendment.

MEMBER ZATKIN: It really has to do with the stage in the process, I think.

MEMBER LEE: Right.

MEMBER SHAPIRO: Can I clarify that? The current ombuds programs are advocates, but before the plan and before the -- and they help with the Department. The issue that seems to be of concern is what happens if you then want to take it to court and then you get litigation. If you call the Department of Health Services ombuds program, they're an advocate for you in the Department with the plan. They don't take you to court. They do

advocate. But the real issue is whether you want the state --

MEMBER LEE: The thing that I suggest is the "may include" language is pretty soft language anyway. And the other thing to note for Tony's -- Tony makes the observation about legal advocacy. Some ombudsman programs do legal advocacy. And there's a question about the scale. The long-term here ombudsman has legal capacity if someone in a nursing home is having a certain care, they can do legal advocacy. So it's not beyond the

pale of what some programs do. This is not doing that. This is not proposing that. But it's saying the "may include" list, as we have it with advise and assistance with problem resolution, in my mind doesn't hit at advocacy.

The next step of this, though, is going back to the state funding something that will spell out from this in more detail what may or may not be included --

MEMBER ZATKIN: Maybe a clarifying amendment -- instead of saying it every stage in the process, you'd say it every stage in dealing with the plan or the regulatory agency.

MEMBER LEE: Great. "At every stage dealing with the plan or regulatory agency."

MEMBER WILLIAMS: Was our intent to exclude legal advocacy? Was that really the

intent?

UNIDENTIFIED SPEAKER: Yeah.

MEMBER WILLIAMS: Then why don't we just say that.

MEMBER ZATKIN: Except for legal process.

MEMBER ZAREMBERG: Can I ask just for a clarification here? You talk about plans in the existing paragraph, the word "plan" doesn't -- isn't in the Recommendation until the end. And I don't know whether this applies to, you know, the

hospitals, procedures, how encompassing this is. I'm trying to figure out your intent here and how broad this is. Is this dealing with plans directly? Is it dealing with medical groups?

MEMBER LEE: The intent is across the board. The intent is -- as many folks around this table know, the problem is not problems and problem resolution; it should be -- as we come to the (inaudible) philosophy, at the lowest possible level, which is in a doc's office to resolve a confusion; it may be in a hospital; it may be with the plan. And so the intent is that this is consumer assistance to resolve the issues, again, at the lowest possible level. So it's not precluding at the point at which this independent assistance may seek to get advice or assistance.

MEMBER DECKER: But, Peter, if you look at the very first line of the second F, it starts by talking about best health plans. So we are putting it in a context of the plans.

MEMBER FARBER: Usually the utilization decisions aren't made by the hospital; they're made by the doctor within the health plan and the protocols that the health plan has. It would be unusual for the hospital to be involved in something like that. I'm trying to think of how they would be.

MEMBER ZAREMBERG: And I appreciate

that, Nancy. I'm just trying to figure out under what circumstances --

MEMBER FARBER: I just think by common practice it's going to end up being a health plan decision issue.

MEMBER LEE: I would suggest that it is -- it would be a friendly amendment because even the best health plans or providers -- it is broader. Internal processes will not be perfect for some consumers. Our program here in Sacramento, most problems we get resolved at a lower level. I mean clarifying communications. I've had people --

MEMBER WILLIAMS: Most clinical decisions are made at the medical group with the IPA. Only certain -- particularly in -- smaller

health plans are much more actively involved. The larger health plans tend to work with the medical groups at the medical groups (inaudible).

CHAIRMAN ENTHOVEN: So you add "for providers."

DEPUTY DIRECTOR SINGH: In the first sentence it would read "because even the best health plans or providers' internal processes will not be perfect," et cetera.

Is there any objection to that technical amendment?

Members, I think that it's time to vote

on Recommendation 7 at this point in time as amended.

Do I have a motion?

MEMBER WILLIAMS: Was the legal advocacy included in that?

DEPUTY DIRECTOR SINGH: I think what they tried to do was to indicate the very end of that sentence dealing with the plan or state regulatory agency.

CHAIRMAN ENTHOVEN: Let me read what I understand we have. It's the last sentence of that paragraph "Appropriate activities performed by external resources may include developing and distributing educational material, providing referrals to existing resources, counseling and

assisting consumers on problem resolution" --

DEPUTY DIRECTOR SINGH: You forgot "advising." "Counseling, advising and assisting."

CHAIRMAN ENTHOVEN: "And assisting consumers on problem resolution at every stage dealing with the plan and regulatory agencies, except legal assistance."

DEPUTY DIRECTOR SINGH: Yes.

DEPUTY DIRECTOR SINGH: "Except legal" --

CHAIRMAN ENTHOVEN: Yeah, "legal assistance."

DEPUTY DIRECTOR SINGH: Is there any

objection to that?

MEMBER LEE: I have an objection to it because I think as pilots, our program doesn't have any legal capacity. I don't know that these pilots should. But to foreclose that as a possibility, there are models that use legal assistance as a rule. I personally think it's not the most effective. But I'd rather just stop at "regulatory agencies" and leave it at that.

DEPUTY DIRECTOR SINGH: Is there any objection just to leave it at "state regulatory agency."

MEMBER LEE: "Dealing with the health plan or regulatory agency."

MEMBER SPURLOCK: Yes.

DEPUTY DIRECTOR SINGH: There is objection?

MEMBER SPURLOCK: Yes.

DEPUTY DIRECTOR SINGH: Therefore, Members, we need a straw vote, please. Those in favor of ending the sentence "dealing with the health plan or state regulatory agency" please raise your hand.

Those opposed?

Neither is a majority.

All right. Then let's go ahead and vote -- a straw poll vote on "dealing with the plan or state regulatory agency, except legal

assistance."

Those in favor please raise your hand.

MEMBER LEE: The other side of the same vote. We'll see if it switches.

DEPUTY DIRECTOR SINGH: Those opposed?

It's 15, so you had several people -- we had more people -- 15.

MEMBER LEE: Move adoption of the whole as amended.

MEMBER FINBERG: Wait. Are we moving on this paragraph, or does it include No. 7?

DEPUTY DIRECTOR SINGH: It's going to be F and No. 7 as amended. Mr. Lee has moved. Is there a second?

(Multiple speakers.)

MEMBER O'SULLIVAN: I'm sorry, does this language include assisting?

DEPUTY DIRECTOR SINGH: It's going to include legal assistance -- except legal assistance.

Those in favor of the amended Recommendation --

MEMBER NORTHWAY: What?

DEPUTY DIRECTOR SINGH: The train is leaving. No more stops.

(Multiple speakers.)

CHAIRMAN ENTHOVEN: Stop laughing, everybody.

MEMBER DECKER: One more issue. We were moving something here, and I don't know if we talked about it. We had moved H on page 5. It's supposed to be in this section.

DEPUTY DIRECTOR SINGH: Thank you very much, Ms. Decker.

All right. Members, it would be F -- we would be voting on F-7 including Recommendation, Subsection H on page 5.

CHAIRMAN ENTHOVEN: We didn't resolve the problem that H is just too vague.

MEMBER FINBERG: I have a suggestion on that. It sounded like you were concerned that the plan would have to do research. So I thought we

could just add "known to the plan" because that would include programs such as Peter's or the Department of --

DEPUTY DIRECTOR SINGH: Ms. Finberg, where would you add this amendment?

CHAIRMAN ENTHOVEN: "Known to the plan"?

MEMBER FINBERG: Right. Where H -- where it says "health plan should" -- "where external assistance programs known to the plan exist."

MEMBER SPURLOCK: Can I make a recommendation before we go any further?

DEPUTY DIRECTOR SINGH: Why don't you

say "are known to the plan." "Where external programs are known to the plan to exist"?

MEMBER SPURLOCK: Can't we say something like during the pilot, they should study the best way to notify consumers about the existence of the external assistance program? I think what we're trying to get is the best way to notify consumers. And the pilot should include that process and that study. So whether it's the plans or whether it's the newspaper or whatever mechanism works the best, the pilot determines that.

CHAIRMAN ENTHOVEN: Bruce, what does

that mean for the --

MEMBER SPURLOCK: I think what it does it moves H, but it rewords it into a new sentence that would say one of the objects of the pilot would be to determine the best way to notifies consumers about the existence of external assistance programs.

MEMBER DECKER: If you look at page 7 on 7 -- Item 7, and go down three lines, it says "such pilot programs should be used to assess" blah, blah, blah, blah, blah. Could we just add it as part of that string?

MEMBER SPURLOCK: There you go.

DEPUTY DIRECTOR SINGH: I'm sorry, where is that, Ms. Decker?

MEMBER LEE: "Such pilot programs should be used to assess" --

MEMBER DECKER: Item 7.

DEPUTY DIRECTOR SINGH: Item 7? Which line?

MEMBER DECKER: Third down.

CHAIRMAN ENTHOVEN: What are the words?

MEMBER DECKER: I'm sorry. "Should be used" --

DEPUTY DIRECTOR SINGH: Could you read the amendment again.

MEMBER SPURLOCK: It says "how to best

serve all health care consumers, how to best inform consumers of the existence of the external assistance program, how to use existing assistance resources more effectively" and the rest of it.

DEPUTY DIRECTOR SINGH: "How to best inform" --

CHAIRMAN ENTHOVEN: "How to best inform the consumers of the existence" --

MEMBER SPURLOCK: Of such a program.

CHAIRMAN ENTHOVEN: Of such programs or --

MEMBER LEE: Okay. Fine.

DEPUTY DIRECTOR SINGH: And then "delete resources most effectively"?

MEMBER LEE: No. That all stays in.

Just insert it in.

CHAIRMAN ENTHOVEN: Then we strike H. We strike H. And so that second sentence reads "such pilot programs should be used to assess how far best to serve all health care consumers, how to best inform consumers of the existence of such programs," et cetera.

MEMBER LEE: Move adoption.

DEPUTY DIRECTOR SINGH: It has been seconded. Those in favor --

MEMBER NORTHWAY: Somebody read for me the -- the amended or whatever sentence -- the last

sentence in F.

CHAIRMAN ENTHOVEN: Yes. Oh, in the paragraph rather than No. 7?

MEMBER NORTHWAY: That's correct.

CHAIRMAN ENTHOVEN: That reads "appropriate activities performed by external resources may include developing and distributing educational material, providing referrals to existing resources, counseling, advising and assisting consumers on problem resolution at every stage dealing with plans and state regulatory agencies (except legal assistance)."

MEMBER NORTHWAY: Does that mean that legal aid societies cannot do legal work for these people? They're an external resource. I mean you're saying that external resources --

MEMBER SPURLOCK: They just can't do --

MEMBER FARBER: They're separate ombuds.

(Multiple speakers.)

MEMBER FINBERG: Actually, there is one ombuds program that is in existence in a legal aid program. Presumably you're not going to prohibit the activities of that person; right?

MEMBER LEE: The point of the "may include" list really is to provide guidance to funding the pilot. This is not to provide direction of existing legal status that, for

instance, the long-term care ombudsman has this authority.

MR. SHAPIRO: The point I was going to make earlier is litigation and court. Advocates provide you legal advice of what's in the health plan, what's in the Code when they go before the DOC and the plan. That's legal advice. That's just telling you this is what the law is and provisions of regulation. I think the parenthetical may go too far. But if you're talking about you guys shouldn't take it to court, that may be a legitimate limitation. But if you're telling these groups they can't give you advice including legal advice, these aren't necessarily attorneys, and I think you may be overstating it.

DEPUTY DIRECTOR SINGH: Members, I

think that this issue has been discussed sufficiently. At this point in time we need to vote.

MEMBER LEE: Let's vote on it as except system litigation if that's okay.

DEPUTY DIRECTOR SINGH: "Except litigation" instead of "legal assistance." Is there objection? It's been moved. It's been seconded.

MEMBER LEE: All in favor.

DEPUTY DIRECTOR SINGH: Those in favor

raise your right hand.

Those opposed.

The Recommendation is adopted 20 to 1.

MEMBER LEE: We are almost done. Moving on.

DEPUTY DIRECTOR SINGH: Ms. Finberg, did you vote in opposition?

MEMBER FINBERG: I did.

DEPUTY DIRECTOR SINGH: Yes. Thank you.

MEMBER LEE: That's okay. I didn't take it personally.

The technical amendment on 8 is the second line, which is -- I'll read the beginning "The Legislation and the Governor should direct the state's agency for managed care regulation to establish and implement by December, 31, 1999, an

independent" and delete the words "within two years."

MEMBER FARBER: Give me the date again.

DEPUTY DIRECTOR SINGH: By 1999?

MEMBER LEE: So "establish and implement by December 31, 1999, an independent third-party review process," et cetera.

MR. SHAPIRO: Can you make that 1/1/2000 because laws become effective the first day --

MEMBER LEE: Sure.

MR. SHAPIRO: -- of the following year. And literally you'd have to --

MEMBER LEE: I just didn't like -- 2000 sounds so far away even though it's the same two years.

MR. SHAPIRO: This is an urgency Bill.

DEPUTY DIRECTOR SINGH: By January 1, 2000.

MEMBER LEE: Great. January 1, 2000.

DEPUTY DIRECTOR SINGH: And deleting "within two years."

MEMBER LEE: Yes.

DEPUTY DIRECTOR SINGH: So that now reads "The Legislature and Governor should direct the state agency for managed care regulation to establish and implement by January 1, 2000, an independent third-party review process that would

provide consumers" --

MEMBER LEE: It's all the same. Nothing else changes

Brad.

CHAIRMAN ENTHOVEN: Peter, my problem with a specific date is what if the Legislators and the Governor dither and haggle for 18 months?

MEMBER LEE: We are not binding upon the Legislators. The point -- the change that this makes --

MEMBER GALLEGOS: What makes you think we would do that, Alain.

MEMBER LEE: -- is if we could be binding on the Legislature or the Governor -- the intent here really -- the two years versus the date is to anchor it, but in particular so that aren't we having the process set up; it's implemented in that period.

MEMBER GILBERT: Peter, in terms of the -- what the intent here is, does it have to be a new entity that would be doing these things? For example --

MEMBER LEE: No.

MEMBER GILBERT: -- on experimental treatments, there are some national entities that -- so is the intent that there has to be a process -- so, for example, if (inaudible) was deemed to be independent enough -- if I contracted

with (inaudible), then I'm okay in terms of experimental treatment, third-party review?

MEMBER LEE: One of the things that we -- to be want punted on with great vigor is the details. And the bullets of what this would include or not include are really left to be fleshed out soon. This is saying that this Task Force thinks that having the right to independent third-party review is important; it should happen; it should be in California. That's, in essence, as

far as we're going. The details that we raised beside them should be done with collaborativeness is not spelled out.

So I mean I can answer what I think about that. But those details will be worked out such that it will be implemented in the next two years.

MEMBER GILBERT: And really -- because the issue is independence. I mean you're saying that even -- there could be a process set up that the independent standard could be met by the health plan contracting rather than having this whole new entity to funnel everything through.

MEMBER LEE: I'm making no comments on that. Right.

DEPUTY DIRECTOR SINGH: Further discussion?

Mrs. O'Sullivan.

MEMBER O'SULLIVAN: Yeah. I think I'd

propose deleting the first bullet there --

DEPUTY DIRECTOR SINGH: Could you please use the microphone.

MEMBER O'SULLIVAN: I propose we delete that first bullet and accept that access to independent review should not require support of a health care provider. The patient should be able to go on their own, and the entity can decide that it's a frivolous -- can have some criteria for

deciding when something's frivolous and let go of it.

DEPUTY DIRECTOR SINGH: Is there objection to that amendment?

MEMBER SPURLOCK: Yes. I mean it seems like we're proscribing and tying the hands of a study or a group to get together to figure it out. Why do we tie the hands ahead of time. Let them work it out and figure out what's best for patients, what's best for the system.

DEPUTY DIRECTOR SINGH: We need to take a straw poll vote on that, Members. We have an objection.

Those in favor of deleting the first bullet, please raise your right hand.

Those opposed?

That first bullet will remain.

Any further -- any further discussion before a motion is made to --

Ms. Finberg.

MEMBER FINBERG: Yeah. I had a comment, and I'm not going to require a vote on an amendment because I know it will fail. So I want you to appreciate that. But my comment is this: This issue independent third-party review is a very important issue. It's a high consumer concern. It's very clear to me that we should have such a process now. We should not wait two years to have

it. I understand that we don't have the time now to hammer out what it should be. But I think we have failed in our duty when we aren't addressing this issue and recommending a standard.

And so although I agree with some of these details of what should go into recommending it, I think we should have done that.

DEPUTY DIRECTOR SINGH: Thank you, Ms. Finberg, for your finish comments. Duly noted.

Mr. Hiepler.

MEMBER HIEPLER: Yeah. Where it talks about appropriateness and all experimental treatments, I'm just proposing -- and it's rather simple, and I'll explain why -- that we put "and all" -- quote/unquote, "experimental-investigational treatments." There's really no denials going on anymore based on experimental, and you can't define either of the words.

DEPUTY DIRECTOR SINGH: Experimental --

MEMBER HIEPLER: "-investigational treatment." Because no one appropriately defines those. No one can define them. And to the degree we're claiming here that we've defined them, we haven't. It might be used against a person on a treatment that's no longer experimental.

MEMBER LEE: Friendly amendment.

DEPUTY DIRECTOR SINGH: Is there any objection?

Okay. Then that sentence will then end with "and all 'experimental-investigational treatments," end quote.

CHAIRMAN ENTHOVEN: Dr. Karpf, can you square us away on that issue a little later.

MEMBER LEE: Have we had this moved and seconded?

DEPUTY DIRECTOR SINGH: No. Would you like to move this, Mr. Lee?

MEMBER LEE: Yeah. Move.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Who seconded?

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Those in favor please raise your right hand.

Those opposed?

Recommendation has been adopted 22 to 0.

MEMBER LEE: I'd like to -- in one

second. I'd like to turn the chair to Assemblyman Gallegos, but before I do that, if I could quickly do a -- 10 is the last one that we have not -- that we have done a straw poll on. This is a broad -- just urging folks to do further evaluation and assessment. I would move adoption of 10 on the next page.

MEMBER DECKER: Seconded.

DEPUTY DIRECTOR SINGH: Those in favor please raise your right hand.

Is there any discussion?

Those in favor please raise your right hand.

Those opposed?

Twenty-three to one. The Recommendation No. 10 has been adopted.

CHAIRMAN ENTHOVEN: Now we come to Arbitration Standards. And this is simply reproducing the Memorandum that Martin Gallegos submitted. So we haven't had the opportunity to include any evaluative information.

So, Martin, I think it might be helpful if you would begin by explaining in general and by points why you think we should do this.

MEMBER GALLEGOS: Thank you, Mr. Chairman and Members.

I felt that it was very important for the Task Force if we're going to deal with dispute

resolution, we cannot neglect the area of binding arbitration. And the proposals that are -- or the recommendations that are in here for arbitration standards were submitted on the meeting of November 25th for your review. I trust you had opportunity to look at them. And if you have any questions or comments -- what I tried to do here

was to try to present an alternative solution to lawsuits. I think this is an effort that can help to control litigation costs. And I think it's an effort that I'm presenting here would be fair and would be speedy and, as I mentioned, less costly for the system.

What I've tried to do -- and I can go over this -- over these requirements one by one -- the other reason I think it's important, I think we've all heard and seen that there have been abuses of the arbitration system in the managed care programs. So I think that we could make some recommendations to the Legislature on how we might want to approach dealing with putting in some kind of arbitration standards.

I can go over these one by one, if you'd like. You've all, as I said, had opportunity to review them. If there is any questions or any comments that any of you have, I'm more than happy to try to answer those or to hear the input from the Task Force Members at this time.

DEPUTY DIRECTOR SINGH: Is there any discussion?

CHAIRMAN ENTHOVEN: What about from the health plans?

DEPUTY DIRECTOR SINGH: Mr. Zatkin.

MEMBER ZATKIN: I'll lead off.

MEMBER GALLEGOS: Gee, I'm surprised

Steve had something to say about this.

MEMBER ZATKIN: As the Panel -- I mean the Task Force knows, we have an interest in this issue. And I appreciate Assemblyman Gallegos' efforts here because there's a lot of thought that's gone into these, obviously.

I guess I have two comments: One is that because of the controversy around the case that we were involved with, we did commission a blue ribbon panel to advise us on how to improve our system, whether it needed improvement and how to improve it. And the panel consists of Assemblyman Phil Eisenberg -- former Assemblyman Phil Eisenberg; Sandra Hernandez, who is a former health director for the City and County of San Francisco; and Retired Judge Gene Lynch from the San Francisco Bench.

And the panel has been meeting for several months collecting information. And they will be submitting a report soon, before the end of the year. And -- so my comment is that -- from my

perspective, I need to wait to see what they have to say about the issue.

I guess the other comment is that it is a very complex issue. And while I know that Mr. Gallegos has worked on this and has a great deal of information about it, we haven't had the

benefit of that discussion and all that thought.
So I'm going to wait and see where the panel is.
It may be consistent with a number of these
recommendations. There are some that I would doubt
that it would be, but I don't know at this point.
I just wanted to put my view out on that.
CHAIRMAN ENTHOVEN: Ron.
MEMBER WILLIAMS: I think that this is
a clearly very important area from the point of
view of health plan members. I think it's clear
that a lot of thought has gone into these.
I think there would be a few concerns
that I would have. I think that one of them is
around the question of a single arbitrator. There
are certain cases that get to be complicated
cases. I think an ability to bring in three
arbitrators where each party can select one gives
people the sense that there is one and one and then
a third party that's selected. I think having that
kind of flexibility is something that can be
helpful.
The other concern I would have is really

the whole question of the written opinions. I
think clearly people need appropriate explanation
as to the findings of the arbitrator. I just think
that if we develop a situation where we start
providing written opinions, we're going to end up
in a situation where we end up back in a litigation

kind of situation in some circumstances.

I think in terms of the question of payment, I think that making certain that there are hardship provisions so that individuals who really don't have the financial means to participate do have a meaningful way to participate. It's important. I don't believe that having a health plan pay for this is something that I would be supportive of.

I think that I would also echo Steve's comments. I think that there may have been a lot of work done. But this is not work that I've seen, work that I'm personally familiar with regarding some of the issues here.

CHAIRMAN ENTHOVEN: All right. If I may add a comment and explanation as to why there are Alternative 1 and Alternative 2 here. I injected Alternative 2 just for the sake of discussion here. In my view, one of the fundamental causes of our cost problem is all throughout the system there are far too many people in too many circumstances who don't have any

incentive or reward for behaving in an economical way. And there's too much free-riding, too much moral hazard, all those terms that we used.

It seems to me that when people use these costly resources of arbitration, which are not

cheap, that they have to have something to lose or something -- some -- leaving aside the people who are really poor, but -- so I suggested the related parties' ability to pay. For people have who have some ability to pay, it just seems to me they shouldn't be able to invoke and lay on all the rest of us -- because this will raise costs. It will be less medical care for us -- the rest of us or else higher premiums.

MEMBER GALLEGOS: And I think, Mr. Chairman, no, that was an excellent idea. It adds balance to the proposal.

If, you know, the Task Force is inclined to not go there and start delving into the area of fees and fee recoveries, you know, I'm certainly amenable to eliminating both Alternative 1 and Alternative 2. I mean, you know, I certainly put it in there because I thought it was something important. But I mean if the Task Force feels that maybe we're going too far getting into the fee issue, we can just amend those out of this proposal -- out of the recommendation. And, you know, I'm sure on this Panel there's going to be

feelings on both sides of those issues.

I think your alternative adds, as I said, a good balanced perspective. But if the Task Force feels like it doesn't want to go there, fine, we can amend those out.

CHAIRMAN ENTHOVEN: Mr. Hiepler.

MEMBER HIEPLER: Let me give you a little reality on this because the costs of arbitration are generally -- in a complex case, are much more costly to the consumer than it is to have a jury trial or to have access to a judge. And I can give you some data on that, and I'll provide that for you.

But to give someone no choice as to whether they're going to be in a binding arbitration setting or to have their Seventh Amendment Right or the First Amendment to the California State Constitution, Section 16 Right to a jury trial and then say we're putting you into this thing where you've got to pay for half of an arbiter; you've got to pay for an attorney -- someone probably did that intentionally.

CHAIRMAN ENTHOVEN: This is going to look like a press conference if you have two or three mikes there.

MEMBER HIEPLER: And then to put the smallest person versus the very large company into a setting that you force them into and then say

"Oh, and by the way, you know, now you've got to pay should you lose, most of the contracts already say that. I would just put as a statement for this whole arbitration discussion that, No. 1, it would

allow free and informed discussions with plan members if it was optional because you would know what you're choosing. Are you choosing to have the ability to go to binding arbitration? And if you are, you know the consequences. Because 99 percent of the people that come to us, they never know that they signed away their rights -- a very important right to be in binding arbitration. And if someone has the choice as to whether to pursue their rights -- and there's only PruCare and Blue Shield that don't have arbitration binding clauses anyway that I know of.

So first if you start with giving them a threshold of do you want to go to binding arbitration or not, and you have a choice, then I think you can put all kinds of inhibitors in there for those that choose to be a part of binding arbitration in a knowing fashion. But to take away the little person's rights once you've thrown them into a very costly procedure -- and I've been in too many of these arbitrations -- you're paying -- you're already -- you're paying twice because you've pay for the judge already, and you pay $5 a day per juror -- 60 bucks a day.

But these arbiters, and especially in the Kaiser setting where you pay for your own and you pay for half of the other one, and they're 3, $400 a day. And there's very few things even in

arbitration that ever settled in one day. That's the reality of it. So my recommendation -- and I'd love to see a straw vote on this one -- would be that we tell the plans that they need to make it optional, binding arbitration or not. And then if someone chooses to be in binding arbitration and someone has knowingly chosen that, then you can ascribe penalties for people who, you know, file these things.

Remember, no one's going to take these things. No one's going to pursue these -- the courthouse doors or the arbitration doors are going to be locked off for the little guy if you prescribe all these penalties in there.

Remember that in most of these situations you do have a contingency fee attorney. There's no reason to ever take one of these. Very few people do it. You hear about those that do it without much research. But you're going to lose. And the agreement already says who's going to pay. They're free to contract in the arbitration agreement. Most of the arbitration agreements say the loser's going to pay. And that's been good 12 times for me, you know, because the other side's always

lost. Because you evaluate those things. You make sure you have a meritorious case.

But to say "We're imposing this costly

system on you; you have no choice, and we're not going to really tell you about it upfront," and then once you're in this costly system that we've imposed on you, then you're going to have to pay if something doesn't go right or if it's a close call and one of the arbiters go against you, it's completely anti consumer. Sounds good in theory. But in reality it's -- so I'd like the opposite for the consumer to choose whether to be in it or not than having it imposed on them.

MEMBER BOWNE: I guess what I'd have to say on this is I think that there are obviously people here who know a lot more about it than I do. And it's a very contentious issue. I would respectfully say that before we as a Task Force or a Commission took a finite stand on this, I really don't think that we know enough to recommend one way or another. And I would be very cautious about coming out -- it's a very complication issue. It's a very contentious issue. It clearly means a lot to a lot of people on all the different sides of the issue. For some, this doesn't go far enough. For some, it goes too far. And while I respect the work that's being done to date, I would caution very strongly about us getting quite this

concrete. And perhaps what we want to say is that it is an important issue to consumers, and that it's something that needs considerable further work

and resolution.

MEMBER GALLEGOS: Mr. Chairman.

CHAIRMAN ENTHOVEN: Yes.

MEMBER GALLEGOS: I just want to say that, again, I feel strongly that if we're going to deal with dispute resolution in the system, we can't ignore binding arbitration.

Let me just try and break this down into its simplest components. It's really not as complicated as it may seem. Section A just says that the arbitrators will be independent; okay? I mean that's basically it. There's been some issues where there have been in-house arbitrators used by health plans. And this just says it has to be neutral. The second one just says that it will be a speedy process. It provides for expeditious interjection when there's a perceived delay. C just says that it will be a single neutral arbitrator, but it still provides an option for a tripartite panel. The reason for the single arbitrator, it's cheaper; it's faster; less cost to the system. D just says that there will be a written opinion provided. And that breaks it down to the least common denominators. That's really what it said in these proposals.

Now, with Alternatives 1 and 2 -- Mr. Chairman, you may want to do a straw vote to

see if the Task Force supports the issue of getting into the fees or not. Mark brought up some very valid points. It's true; in the system, the enrollee doesn't have a choice. You sign up for a health plan; you know you're going to get binding arbitration. You really don't have much of a choice in that regard. But this -- my proposals and my recommendations don't address that issue. So, again, that's something that we might want to look at getting involved in or not.

MEMBER ZAREMBERG: Can I ask a question. On the one arbiter, is that appropriate in all cases? I mean in the larger cases, should there be three? I mean I just --

MEMBER GALLEGOS: Two things on that, Allan. It lists the $200,000 cap and says -- so there isn't that limit to deal with. This would allow arbitration in all cases. And the recommendations do allow that if the parties agree after disputes have arisen, they can go to a tripartite panel if the parties agree. But for the most part, this recommendation is that you go with a single neutral arbitrator.

MEMBER ZAREMBERG: Regardless of the amount at stake.

MEMBER GALLEGOS: That's correct.

Yes. So that's where the big cost savings can come in, because now you can have cases above $200,000

that can go to arbitration.

MEMBER LEE: I'd like to make a suggestion that we actually go through and do votes on A, B, C, D and actually go through them. That's the way we've generally gone through on other ones. And we'd have general comments, discussion. I know there's a broader suggestion to have an additional option which is arbitration would be optional across the board, but maybe go through these and that sort of would be an additional option.

CHAIRMAN ENTHOVEN: Dr. Karpf.

MEMBER KARPF: As a point of information, what are we arbitrating? Are we arbitrating medical decisions here? Are we arbitrating malpractice decisions?

MEMBER HIEPLER: Anything and everything.

MEMBER KARPF: Anything that comes under the sun that could happen in a medical care environment.

MEMBER SHAPIRO: The answer to that is each plan specifies what issues they impose binding arbitration on. Some plans include medical malpractice; some plans don't. Some plans have coverage; some plans don't. But most every plan as

a condition for joining the plan says you waive

your right to go to court, and we impose binding arbitration on the following types of disputes. You have no choice.

I should let Mark know that the Legislature considered the issue of giving people choice, and they rejected that issue and said better we let them compel binding arbitration but make sure it's reformed and that it's a fair process. Quick, cheap, fair.

I'm not saying I don't advocate for that, but that would undo essentially the current practice. And it's very controversial.

CHAIRMAN ENTHOVEN: Was the choice that you'd pay more if you wanted not to have arbitration?

MR. SHAPIRO: No. The choice was -- and I think New York may be the only state that was referenced in a Center for Health Care Rights Report was a health plan could not compel you when you signed up for the plan to waive your right to court. You'd basically say "I want to preserve my right to go to court, and you can't force me." In California, they say "Fine. You can't join my plan."

CHAIRMAN ENTHOVEN: What incentive do you have to waive your rights if you aren't offered -- it's --

MR. SHAPIRO: We can tie it to

(inaudible). I just make the point that there's been long debate on whether that should be optional. Those in favor of the pure option lost that battle. And the discussions -- and there was background material provided to the group -- has been "All right. If health plans are going to be allowed to compel you to waive that right" -- and most do -- "and they're going to tell you for the following kinds of disputes, excluding medical malpractice, you must go to the binding arbitration," then is it going to be quick? Is it going to be cheap? Is it going to be fair? Which is a substitute for litigation. And these recommendations go to that issue. It's quicker with one. It's got some big cases to decide. It's cheaper with one. It's fair with an independent. And you get a court decision now. You don't necessarily get a written decision in your arbitration case. Even though Ron said well, that might lead to litigation, you've waived your right to go to court. This is it. You want to see what the decision was on that.

MEMBER HIEPLER: The only way to unwind that is to show fraud on the arbiters. And every time we win, the health plan goes in and says "Oh, there had to have been fraud." But that's -- that's never -- so "binding" means binding. It's

over.

CHAIRMAN ENTHOVEN: I'd like to pick up -- well, hold it. I'd like to pick up on what Rebecca said earlier. I find myself confused and uninformed. I just don't feel I'm on top of this issue at all. And she raised the question should we even address arbitration in this Task Force.

MEMBER FARBER: Yes.

CHAIRMAN ENTHOVEN: I wonder if we could -- does everyone say yes, we should address it --

MEMBER FARBER: Yes, we should.

CHAIRMAN ENTHOVEN: -- or yes, we should have a straw vote?

MEMBER HIEPLER: I would just request --

CHAIRMAN ENTHOVEN: Could we just have a straw vote: Should we address arbitration in this Task Force? Yes or no. Those who want to address arbitration please raise your hand.

Those who would prefer not to address arbitration please raise your hand.

DEPUTY DIRECTOR SINGH: Fourteen to --

CHAIRMAN ENTHOVEN: Twelve with -- Hartshorn had his hand up.

DEPUTY DIRECTOR SINGH: Fourteen to twelve.

MEMBER LEE: So the majority want to

address it. So now we'll address the best way we can.

MEMBER ZAREMBERG: Let's vote on these.

MEMBER HAUCK: Let's vote.

DEPUTY DIRECTOR SINGH: Could we have a motion to adopt Recommendation 9-A.

MEMBER LEE: So moved.

MEMBER BOWNE: So moved.

UNIDENTIFIED SPEAKER: Second.

DEPUTY DIRECTOR SINGH: Those in favor please raise your right hand.

Those opposed?

The motion failed 13 to 6.

Is there a motion to adopt Recommendation 9-B?

MEMBER LEE: What was the vote on that?

DEPUTY DIRECTOR SINGH: Thirteen to six.

CHAIRMAN ENTHOVEN: We did not get 16 votes.

MEMBER FARBER: How can you vote on B after you've defeated "A"?

DEPUTY DIRECTOR SINGH: Oh, well --

MEMBER FARBER: That kind of called the question right there.

CHAIRMAN ENTHOVEN: Well, I think B still makes sense even in the absence of the other

one.

MEMBER LEE: Well, if Allan might vote for it, we can --

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Members, would it be easier just to vote for all of Recommendation No. 9 -- A, B, C, D -- and --

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Okay. You want to go through each subsection even though it might not make sense --

MEMBER LEE: Yes.

DEPUTY DIRECTOR SINGH: Is there a motion to --

MEMBER GALLEGOS: Mr. Chairman.

CHAIRMAN ENTHOVEN: Yes.

MEMBER GALLEGOS: I don't understand how if we don't pass "A," we're going to vote on an expeditious system, a faster, cheaper system and written opinion of an award if -- I mean we don't even support the fact that -- you know, "A." I mean --

CHAIRMAN ENTHOVEN: Well, no. We could have other than independent ones that would be expeditious, rapid selection and meet those criteria.

MEMBER ZATKIN: If I could comment, Mr. Chairman, on the --

Mr. Gallegos, on the first item, the blue ribbon panel may well come in and recommend that. And if they do, I'll support it. I don't know that they will.

MEMBER GALLEGOS: It's too late by then.

MEMBER ZATKIN: It's not too late for the Legislature. It may be too late for this group. But the issue, frankly, is that if we go to JAMS or we go to AAA, we've been criticized for having too closed an arbitration panel. And JAMS and AAA operate with a fixed panel. It's not an open panel at this point. So we have a dilemma. We either have an open panel, or we have an independent group to administrate. So we're trying to kind of reconcile those two competing issues. And that's why I'm not clear where the blue ribbon panel is going to come out. That's why I didn't vote for that. It may well be the right thing.

MEMBER GALLEGOS: See, the problem is the Governor is going to use the Task Force report as a guideline for Legislation. And if we don't deal with arbitration in the Task Force Report, the issue's dead. Because if a Bill lands on his desk, he's going to veto it. He's going to say the Task Force didn't agree -- didn't deal with it.

DEPUTY DIRECTOR SINGH: I don't think that's necessarily true.

MEMBER GALLEGOS: You don't sign and veto the Bills; the Governor does.

MEMBER BOWNE: Excuse me. I'm getting the perception that if a vote goes the way that the people from the Legislature want it, they will use the Task Force recommendations to further that cause. But if a vote doesn't support them, they still have the flexibility to push that cause.

MEMBER GALLEGOS: Yeah, to a dead end. I mean the Governor's made it clear to the Legislators that -- he's done it in writing -- that he's going to use the Task Force Report as a guideline. So if we don't deal with an issue and an issue comes through the Legislature --

MEMBER BOWNE: But we're dealing with the issue. We're voting on that.

(Multiple speakers.)

MEMBER SCHLAEGEL: Let's move through the vote.

CHAIRMAN ENTHOVEN: Let's take Recommendation B.

DEPUTY DIRECTOR SINGH: Is there a motion to adopt Recommendation B.

UNIDENTIFIED SPEAKER: I move to adopt Recommendation B.

UNIDENTIFIED SPEAKER: Second.

DEPUTY DIRECTOR SINGH: Those in favor please raise your right hand.

Those opposed.

The motion fails 15 to 5.

MEMBER FINBERG: What if we took out the word "independent"? Could we vote? That sounds like that's the problem when we're including "A."

DEPUTY DIRECTOR SINGH: I think that we've discussed the issue of independent --

(Multiple speakers.)

MEMBER LEE: No, we haven't.

MEMBER BOWNE: Hold on.

(Multiple speakers.)

UNIDENTIFIED SPEAKER: That's a friendly amendment.

MEMBER RODGERS: I'd like to make a motion that we replace B with -- by striking "independent" and just use "arbitration assistance used by plans to provide expeditious resolution of disputes including rapid selection," et cetera et cetera, et cetera.

DEPUTY DIRECTOR SINGH: Is there a second?

MEMBER BOWNE: Second.

DEPUTY DIRECTOR SINGH: Those in favor of the amended B please raise your right hand.

Those opposed?

All right. The Recommendation has been adopted 20 to 1. I'm sorry, 20 to 2. I

apologize.

Recommendation No. C. Is there a motion to adopt?

No motion to adopt Recommendation C? All right.

MEMBER GALLEGOS: I'll move it.

DEPUTY DIRECTOR SINGH: Gallegos.

MEMBER GALLEGOS: Maybe I'll get a courtesy second.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: All right. Those in favor of Recommendation C please raise your right hand.

Those opposed?

CHAIRMAN ENTHOVEN: I just don't understand it.

DEPUTY DIRECTOR SINGH: The Recommendation fails 14 to 4.

UNIDENTIFIED SPEAKER: What was the vote on "A"?

DEPUTY DIRECTOR SINGH: Failed 15 to 5.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Wait. I'm sorry. Thirteen to six.

Recommendation D, is there a motion?

MEMBER FARBER: I'll move.

DEPUTY DIRECTOR SINGH: I'm sorry, Ms. Farber?

MEMBER FARBER: Yeah.

DEPUTY DIRECTOR SINGH: Is there a second?

MEMBER FINBERG: I second.

DEPUTY DIRECTOR SINGH: Those in favor of Recommendation D please --

MEMBER SPURLOCK: I'd like to discuss --

DEPUTY DIRECTOR SINGH: Dr. Spurlock.

MEMBER SPURLOCK: Thank you. This is part of where the complexity comes in because of what Dr. Karpf was alluding to earlier with the malpractice decisions.

Since we took off the 200,000 cap or talking about this outside of the 200,000 cap, there's an issue with physicians in notification of awards for malpractice under $30,000. We dealt with this in the Legislation last year that Dr. Gallegos is well aware of with AB103. And the principle was that there would have to be limits to what's notification for malpractice awards.

Secondly, there is a national practitioner data bank that includes all awards above the threshold amount. In this case it's $30,000. And that's useful for a physician to travel between states and between institutions so that everybody has access to that information.

I think that we have to keep those

principles in mind. And so I would say that without amending this to include the current law that was just chaptered into existence from AB103 that we'd have some inconsistencies that I could not support.

MEMBER GALLEGOS: Mr. Chairman, just to answer that briefly. This says that the written opinion would be with the agency which -- whatever that is that it's going to ultimately oversee managed care. I mean it wouldn't -- I mean the public would have to go to the DOC or to OSHA or whatever and request the written opinion and the written award. I mean it's not like it would be distributed to the L.A. Times and everybody. It would have to be in writing, and it would be submitted to the regulatory agency.

I mean what we can do, if this eases some concerns, we could amend that to say, you know, upon request of, you know, a member of the public.

MEMBER SPURLOCK: (Inaudible.)

CHAIRMAN ENTHOVEN: Is this something that --

MEMBER GALLEGOS: Exactly, Bruce.

CHAIRMAN ENTHOVEN: Is this something that exists already, and you're just asking about its promulgation or -- I mean I'm a little bit concerned about -- do you have to write something like what the judge does for 50 pages, or does that

happen anyway? I just --

MEMBER GALLEGOS: It would just be the judgment and the award of the arbitrator. I mean it's not the U.S. Supreme Court.

MEMBER SHAPIRO: Mr. Chairman, the point of this Recommendation is currently if you're joining an HMO, you have no idea of their record on arbitrations. And many of them don't do medical malpractice. We're not talking about medical malpractice here. Most of them don't do medical malpractice. Only a few do.

MEMBER SPURLOCK: So should we exclude that, then?

MEMBER SHAPIRO: I'm just making an observation that if you want to see dispute resolution data on an HMO, it's currently not available. The reference to excluding personal and confidential information there was to take out name of patient and other things. You're trying to get a sense of whether or not you have a lot of arbitrations going on among plans. And right now that is simply secret information.

So, again, to the extent you want consumers in a market to understand that some plans send a lot of people to arbitration and they win or lose a lot without names -- that can include physicians -- it simply gives you general data on the record that the state agency then complies.

MEMBER SPURLOCK: Including physicians in that aspect, that would be fine.

DEPUTY DIRECTOR SINGH: Could I ask Ms. Singer to read that amendment? She's typing in these Recommendations as we speak.

MS. SINGER: I'm not sure I got the physician part, but I've got copies of written opinions excluding personal and confidential information including award amounts should be available to the public upon request through the state agencies for regulation of managed care.

MR. SHAPIRO: I think if you add the parenthetical remark "excluding personal (inaudible) patient and physician identifying information. Because we don't want to just -- not only the name, but any identifying information.

CHAIRMAN ENTHOVEN: Excluding -- what is it? Personal, confidential and any identifying?

MS. SINGER: "Excluding personal, confidential and patient and physician identifying information."

DEPUTY DIRECTOR SINGH: Is there any additional comments?

MEMBER WILLIAMS: Yeah, just one question.

Part of the dilemma is I think a lot of these proposals in general are very good, but I

just don't feel I've got the fact base in front of me to really be able to vote for some of these.

In this case, for example, how does this affect the health plan's credentialing obligation? If it's something the health plan knows about relative to this situation, how does this play through the whole credentialing and peer review process in terms of that? I just don't know the answer to that.

MEMBER NORTHWAY: How do you deal with it now?

UNIDENTIFIED SPEAKER: I think the (inaudible) question is how does it play now in the credentialing process?

MEMBER NORTHWAY: You're doing an arbitration now. How do you deal with it now?

MEMBER WILLIAMS: There is not a report written up in a reportable incident of it, as I understand it now.

MR. SHAPIRO: These are arbitrations against the plan. This is a plan that is party to an arbitration. The plan will -- this is a doctor -- if it's med mal -- and it may not be; it could be coverage -- the plan has the information. The plan knows the decision. The plan has to pay out an award or not. The plan is only one who knows that answer.

MEMBER WILLIAMS: I guess my concern is

that sounds good. I don't have the fact base here. That may turn out to be exactly what happens. But for me it's really a fact-based question to have the facts to say all this sounds good; it's a good recommendation and to have the fact base to be able to vote "yes" on something as complicated as this -- you know, I don't have the information. It's just very hard for me.

DEPUTY DIRECTOR SINGH: There is a motion on the floor to move to adopt Recommendation D as amended and it's been seconded.

Those in favor please raise your right hand.

Those opposed?

The motion has been adopted 16 to 2.

Members, we next move to Alternative 1 and Alternative 2, which is under Subsection E.

CHAIRMAN ENTHOVEN: Martin suggested we just drop that. Is that all right?

UNIDENTIFIED SPEAKER: So moved.

MEMBER GALLEGOS: Yeah, I mean if the Task Force is so inclined. That's fine with me.

MEMBER HAUCK: I move we drop those alternatives.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Let's take a vote on deleting Recommendation No. E.

Those in favor of deleting Recommendation No. E please raise your hand.

Those opposed?

Sixteen to four. The -- E has been deleted.

Members, Recommendation No. F. Is there a motion to move Recommendation F?

MEMBER HAUCK: So moved.

DEPUTY DIRECTOR SINGH: Is there a second?

MEMBER SCHLAEGEL: Second.

DEPUTY DIRECTOR SINGH: Those in favor of Recommendation F, please raise your right hand. We're on Recommendation No. F, Mr. Chairman.

CHAIRMAN ENTHOVEN: I just had a question. Sorry, I was distracted for a moment.

Is this to be found by the regulator or found by the court to be (inaudible)?

UNIDENTIFIED SPEAKER: Do we have a vote here?

DEPUTY DIRECTOR SINGH: We have a discussion. I'm sorry.

Mr. Chairman, your question?

CHAIRMAN ENTHOVEN: I just -- is this found by the regulator or by the court?

MEMBER SHAPIRO: It's the regulator to avoid the court.

MEMBER ZATKIN: Two points -- are we having discussion or a vote?

(Multiple speakers.)

MEMBER ZATKIN: I think there are two points in the process: One is before the arbitration starts, and I think there the issue is whether it should be a state agency or a court. And then once the arbitration starts -- and then typically it's the arbitrator who decides if things going awry. And so this Recommendation basically says the state agency would manage both those points in the process as opposed to having the courts deal with the pre-arbitration aspect and then have the arbitrator deal with it after it starts. And I guess I would subscribe to the approach that has the court do it first and then the arbitrator rather than have the state agency get into the middle of arbitration, which is (inaudible).

CHAIRMAN ENTHOVEN: As written, it gives the state agency a large amount of power.

MEMBER ZATKIN: That's what I'm saying. That was my point. I guess I didn't make it (inaudible).

MEMBER GALLEGOS: Mr. Chairman, this is -- for example, someone enrolls in a plan. They have 60 days to -- you know, for binding arbitration. And the regulator sees that that

period is constantly being ignored; okay? It's taking 120 or 150 days for enrollees to get into

arbitration. Then what the regulator can do is come in and say, "You know, Plan, you have a history of not meeting your contractual obligations under binding arbitration. You can no longer require the party to continue in that binding arbitration."

CHAIRMAN ENTHOVEN: So your intent is definitely the regulator.

MEMBER GALLEGOS: Sure. I'd like to keep it out of the courts.

MEMBER BOWNE: This is going to be the regulator that's got all these political people appointed by the Assembly and the Senate?

(Multiple speakers.)

MEMBER GALLEGOS: (Inaudible) political people appointed by the Governor and only one by the Assembly and only one by the Senate and three by the Governor politically appointed.

DEPUTY DIRECTOR SINGH: Members, let's go ahead and vote on Recommendation F. It's been moved and seconded.

Those in favor of Recommendation F please raise your right hand.

Those opposed?

Eighteen to seven. The Recommendation

has been adopted.

MEMBER FINBERG: I have a procedural question because I assume we need to go now to vote

on the Paper. And it seems like sometimes we talk about adopting the Findings, which is what I thought we would be voting on, and sometimes we're saying Findings and Recommendations. And so my question is: Am I voting for the Paper part without the Recommendations? Because that's what I thought we would be doing.

DEPUTY DIRECTOR SINGH: Ms. Finberg, the reason we've said sometimes Findings is because some of the Papers have only had Findings and no Recommendations. What the Task Force agreed to several meetings ago was to adopt the entire Findings and Recommendations section.

MEMBER FINBERG: That isn't how I understood what we agreed to.

MEMBER LEE: I thought we were just dealing with (inaudible), so you can now vote on just the findings. We've already done --

DEPUTY DIRECTOR SINGH: You've already adopted the Recommendations or they haven't adopted them.

MEMBER LEE: Some people don't want to be on record ever saying they supported a Recommendation. Just to be clear, if we're going now on Findings, Jeanne, hates external ombudsman

and she doesn't want to be on record supporting that.

MEMBER O'SULLIVAN: It should only be

Findings.

DEPUTY DIRECTOR SINGH: Then we need to have a motion to adopt the Findings.

MEMBER LEE: So moved.

UNIDENTIFIED SPEAKER: I have proposed motion. We kind of went over it before, but I would like to formally propose that we recommend as part of the Task Force on the issue of arbitration that all arbitrations because of the significance of waiving a Constitutional Right be made voluntarily by the plan so that you can knowingly and intelligently waive your right to a jury trial. And that's the whole motion.

MEMBER LEE: Second.

MEMBER HIEPLER: The proposal would be that all plans be required to make it optional. Then you force the enrollee to knowingly and intelligently waive that.

CHAIRMAN ENTHOVEN: Can they include their estimated costs if they believe the people who don't agree to arbitration and do go to court cost more.

MEMBER HIEPLER: That's not part of the pending motion. If you'd like to (inaudible).

(Multiple speakers.)

CHAIRMAN ENTHOVEN: In other words, you're saying you've got a free ride. That is, it costs you nothing to insist --

MEMBER LEE: Arbitration and court are both very expensive. And in terms of loser pays whether it's an arbitration -- the loser is the loser. Neither of those processes --

MEMBER HIEPLER: In most of the contacts -- I'm not prohibiting that. I'm just allowing them to knowingly and intelligently be informed. And most of the plans do provide that the loser pays in their arbitration agreement. So if they want to say, you know, you can choose between the two and -- I'd let freely contract however they want.

But I just think we should propose a motion that says whether we're going recommend or mandate that plans be able to -- no, that plans should be able to force to offer the option of binding arbitration or using the regular judicial system that they've already paid for.

CHAIRMAN ENTHOVEN: Sara, have you got words -- you want to read --

MS. SINGER: I made something up here. Arbitration should be optional or a health plan member should be able to use the regular judicial system.

Mr. Hiepler, is that --

MEMBER HIEPLER: Yeah, I can -- let me just make it better. The proposal is that "All HMOs, insurance companies be mandated to give the

option to the consumer as to whether they will be in binding arbitration or be able to pursue normal judicial avenues in the event of a dispute."

MEMBER WILLIAMS: How does that affect self-funded plans or ERISA?

MEMBER HIEPLER: I'm sorry?

MEMBER WILLIAMS: The question, Mark, is how would that affect self-funded plans or ERISA exemption or self-funded plans? Is it the concept that they're outside of that requirement.

MEMBER HIEPLER: Well, even in an ERISA plan, if you have binding arbitration, you're going to arbitration. So this would apply to all plans, whether they're self-funded in the true sense of self-funding or whether I choose to have my employees in your plan.

MEMBER WILLIAMS: Thank you.

CHAIRMAN ENTHOVEN: Read the words, please.

MS. SINGER: "All HMOs and insurance companies should be mandated to give the option to the consumer to use arbitration or the normal judicial process."

MEMBER ZATKIN: That was not what was said. It was all health plans, because he intended to include self-funded plans.

MEMBER FARBER: "Should be mandated"?

MS. SINGER: "Should be mandated to

give the option to the consumer to use arbitration or the normal judicial process."

MEMBER HIEPLER: "In their health care enrollment forms."

DEPUTY DIRECTOR SINGH: "Should be given the option in their health care enrollment forms."

MEMBER ZAREMBERG: Can you impact ERISA?

(Multiple speakers.)

MEMBER ZATKIN: You can't impact self-employment.

MEMBER ZAREMBERG: You can express the intent.

MEMBER LEE: You can try.

MEMBER HIEPLER: That won't change ERISA, Alain? You're still going to have the same remedy or lack of remedy, but you'll be able to pursue it in the normal judicial manner as opposed to private arbitration.

MS. SINGER: Do you need to say "unless preempted by ERISA"?

MEMBER HIEPLER: No. I mean you're

going to have the same rights -- we're not doing anything with ERISA. You have the right to go through the normal judicial pattern, or can you knowingly and intelligently waive your arbitration rights as opposed to just being surprised and find

out "Oh, golly, I'm in arbitration. I didn't know I gave up a Constitutional Right."

DEPUTY DIRECTOR SINGH: This amendment has been moved and seconded. Are the Members ready to vote for this new recommendation?

MEMBER FINBERG: Yes.

DEPUTY DIRECTOR SINGH: If so, please raise your right hand if you are in support of adopting the new Recommendation.

Those opposed?

Twelve to eleven. The motion fails.

CHAIRMAN ENTHOVEN: All right. That finishes --

DEPUTY DIRECTOR SINGH: Members, is there a motion to adopt the Findings.

MEMBER SCHLAEGEL: Move we adopt Findings.

MEMBER LEE: Mr. Schlaegel has moved. Is there a second.

MEMBER LEE: Second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting the Findings please raise your right

hand.

Those opposed?

Twenty-three to zero. The Findings have been adopted.

CHAIRMAN ENTHOVEN: All right. Now --

MEMBER GALLEGOS: Mr. Chairman?

MEMBER GALLEGOS: I move to adjourn.

CHAIRMAN ENTHOVEN: Let me just say we need to take up --

(Multiple speakers.)

CHAIRMAN ENTHOVEN: Hold it.

MS. SINGER: I think that the Chairman will probably address this, but we did a calculation of the time that we expected Papers to take and how far we had to get tonight in order to finish tomorrow. And we really need to do one more Paper today.

DEPUTY DIRECTOR SINGH: Actually, I think the Chairman is noting the fact that we calculated time for the Public Perceptions Paper because originally we were going to adopt --

MS. SINGER: Even if we don't include the Public Perceptions discussion tomorrow.

MEMBER LEE: Can we pick an easy one?

(Multiple speakers.)

CHAIRMAN ENTHOVEN: All right. But no more Mr. Nice Guy tomorrow.

DEPUTY DIRECTOR SINGH: Members, that

just means that everybody will need to stay until we're finished because tomorrow we still have stuff. That's all that would mean.

(Multiple speakers.)

MEMBER SPURLOCK: Why can't we have time limits and then the Body has to move to extend

the time limit. So at the time limit, no matter where we are, we vote. And if we want to talk more, we can vote to extend the time, period.

(Multiple speakers.)

MEMBER LEE: Is there a reason we can't start at 8:00 tomorrow?

DEPUTY DIRECTOR SINGH: We have to start at 8:30, I'm sorry, Mr. Lee, because it's been noticed.

MEMBER LEE: Oh, it's been noticed, of course. Sorry.

DEPUTY DIRECTOR SINGH: But we can start promptly at 8:30, Members. We started at almost 9:00 today. So if we start promptly at 8:30.

MEMBER WILLIAMS: Well, I think Regulatory Organization.

CHAIRMAN ENTHOVEN: Then Medical Necessity and Practice of Medicine --

MEMBER SEVERONI: Let's do one more. We can do one more.

CHAIRMAN ENTHOVEN: Could we pick an easy one like New Quality Information Development?

UNIDENTIFIED SPEAKER: How about Vulnerable Populations?

(Multiple speakers.)

MS. BELSHE: The problem with doing Vulnerable Populations is it references support for

a whole variety of Recommendations and other Papers that have yet to be acted upon by the Task Force.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Members, before we go to New Quality Information, we need to give our court reporter a break. So can we please have a five-, ten-minute break, please.

(Brief recess.)

CHAIRMAN ENTHOVEN: All right. New Quality Information. The staff has passed out a new version of the document dated 12/12/97 hot off the computer. By now the computer has come to life on the line-in, line-out. So that you can see the changes from what you have in your book, and those now are clearly indicated. And Clark has made a friendly amendment to himself to Recommendation 5 based on a trip that he has just made and a conversation with one of the to gurus (inaudible), which he'll talk about a little bit.

Clark.

MEMBER DECKER: Can I clarify on time

keeping. What's our amount we're going to give to this?

CHAIRMAN ENTHOVEN: Well, let's see.

VICE-CHAIRMAN KERR: Thirty-five minutes. I don't think I need that much. Just give me a few yeses and we'll be out of here.

MEMBER DECKER: So 35 minutes?

CHAIRMAN ENTHOVEN: Yeah, 35 minutes.

VICE-CHAIRMAN KERR: We all want to get to dinner, and my voice won't last any longer than that. So we're going to get done here.

Let's go right to the recommendations. And there's been no change in the first one, which we discussed last time, which essentially is the idea that in order for the state to be a real player in data, we've got to sort of be like every other state and have broad oversight of the program by the Legislature but not require the Legislature and the Governor to agree and sign off on every single addition or subtraction from the data element. But it makes a lot more sense to bring up the stakeholders who could make those decisions under the broad -- to the oversight of the Legislature per say. That's the basic concept.

CHAIRMAN ENTHOVEN: We really need to get all the Task Force Members up here because to be able to function, we're -- unless this is going

to be unanimous, we need to have 16 people here.

Ellen?

Martin, we really --

MEMBER GALLEGOS: Aye.

CHAIRMAN ENTHOVEN: That's not good enough.

All right. Let's see. Just -- what have we got here? Twenty-four other. That's not too

bad.

All right. So Recommendation --

DEPUTY DIRECTOR SINGH: No. 1-A. Is there any discussion?

MEMBER RODGERS: Can we move it?

DEPUTY DIRECTOR SINGH: It hasn't been moved. But there's discussion first.

(Multiple speakers.)

MEMBER ZAREMBERG: I'd like to ask the people who work in this area -- to me, this appears to be a blank check for the state agency to order any data without regard to cost. And I just have a concern about that for the hospitals, health works and whether there should be some controls.

CHAIRMAN ENTHOVEN: Clark.

VICE-CHAIRMAN KERR: The control is the Body that's set up. It will include providers, hospitals and everybody else who will be regulated, consumers, purchasers. It will be the stakeholders, per se. And they will take into

account the issues we discussed before of cost, of benefit issues and so on.

MEMBER LEE: That's spelled out in B.

MEMBER KARPF: From the perspective of a larger provider, if there is a standardized data set that is being required -- is being used by all folks who are evaluating us, it's a lot better than being asked for different data by every different

person who wants data.

The one thing that I would wonder is as we develop these advisory bodies and blue ribbon panels, should they be anchored to "OHNO" or OHSO or "NONO" or whatever --"SOSO" -- it's going to be so that they don't float out there and have no home. And of all the 16 or 13 panels that we've generated, I think we need to go and map them to some kind of organization that will keep them comprehensive and connected.

MEMBER SPURLOCK: Is that the amendment?

CHAIRMAN ENTHOVEN: How do we do that?

DEPUTY DIRECTOR SINGH: Would you propose an amendment then to do this.

MEMBER RODGERS: Just a clarifying question, which might help.

Michael, do you simply mean making sure that the cross-references are there so that they're

connected to OHSO, or do you mean more or organizational detail?

MEMBER KARPF: No. Just that as we take a look at the panels like the blue ribbon panel, whatever they be, that that panel either constitute a report to OHSO, that OHSO be the Body that essentially defines data on this.

CHAIRMAN ENTHOVEN: No. In this case it would be to OSHPD, actually, because OSHPD is

the entity that does this particular --

MEMBER KARPF: Not after we -- not after --

VICE-CHAIRMAN KERR: This will be separate panel that will advise OSHPD, I think.

MEMBER SPURLOCK: But Michael's point is that then we don't link up with the managed care improvements and regulations and all the efforts that we're doing on the rest of it. I mean I think there's a disconnect when you don't have that anchored within that Body. I think that's what you're talking about, Michael.

MEMBER KARPF: Yes. I mean if we're going to put a body together that's going to start to define things, start develop standards, you've got to have all the information pieces coming into that. And that Body has to have control of the definitional process. You can't -- we're taking a lot of this activity out of OSHPD. You can't leave

this in OSHPD. Just so happens OSHPD does that now. But it may not be doing that once this Body is constituted and mandated.

MEMBER ZAREMBERG: Can I speak to Dr. Karpf? And I appreciate what you're saying. Let me give you a particular perspective of what I'm talking about here. It may be significant to OSHPD to have data. But without some coordination, you don't know what the consequences are in terms of

cost, how that affects access because there is an elasticity in the market. So I think I appreciate what you're saying. It also goes to my concern that there's a blank check.

I'd really like to hear from the hospitals who may have to deal with this issue.

MEMBER KARPF: I am a hospital.

MEMBER ZAREMBERG: Okay.

MEMBER KARPF: Since I'm responsible for the three UCLA hospitals.

MEMBER FARBER: Can I talk now?

CHAIRMAN ENTHOVEN: Yes.

MEMBER FARBER: This may be the first time you and I have agreed.

MEMBER ZAREMBERG: No, it's not the first. I've been watching us today. We have a couple of votes together.

MEMBER FARBER: Okay.

MEMBER NORTHWAY: She made a mistake twice.

MEMBER FARBER: I think the issue for hospitals is really a significant one. As much as the health plans complain about the onerous regulation, hospitals have been in business a lot longer and have a lot more. And when I spent time with staff on -- I can't think of the display that's in the Regulation of the Industry Paper that we're going to talk about tomorrow, I gave them a

comprehensive list of what agencies the hospital routinely reports to and is obligated to give data to now. And it's an excessive list. I'd refer you to that Paper, but we'll see it all tomorrow.

I think that the hospitals want to participate in defining good outcomes and quality. And they're falling all over their feet right now. The Joint Commission has mandated that we're going to do this, but they have not narrowed in any sensible way what the choices are going to be from data systems. They're allowing a whole plethora of selections. And what I'm concerned about is a mandate, that is, we'll get five years out just long enough for the hospitals to buy and implement new data systems and then at the end of that five years they say "Okay. We're going to pick this one." And everybody's had a huge capital investment in staff training and data collection

sunk cost that is now useless.

I guess when I look at a statutory --

change from a statutory to a regulatory approach of data collection, my hope would be that it would be simplified.

MEMBER KARPF: That's right.

MEMBER FARBER: But I fear it might not be. And to add this expense profile to hospitals whose reimbursement have been steadily dwindling and who all face huge capital costs in reaching

seismic safety standards by the year 2008, you're beginning to pose some very difficulty capital issues for hospitals. And I think I would want my hospital to have very fine data systems that define outcome. I think that's how we improve our processes. Something we all very much want. What I would hope is there would be some uniformity.

MEMBER KARPF: I would agree with that. And I think the best opportunity to have uniformity is to have one regulatory agency that, in fact, sets the standards and sets the data elements as opposed to having five or six, and also to try to get those data elements narrowed or at least organized in such a way that when plans ask you for data elements or you've got to publish data elements, you're collecting the same data all the time.

MEMBER FARBER: That's not what this says, unfortunately.

CHAIRMAN ENTHOVEN: Bruce. And then I think we need to figure out how to say it. I don't think there's any difference in the intent here.

MEMBER FARBER: Right.

MEMBER SPURLOCK: I just want to elaborate a little bit about some of the activities. When a light bulb went on in this group about the value of information and data earlier this year, it went on elsewhere. Nancy

pointed out the Joint Commission. NCQA is actually just doing hospital data. I'm working with PBGH and getting hospital data on C-sections and on hospital satisfaction. There are a lot of people that want data. It's all over the map.

When we talk about streamlining audits and streamlining oversite, this is all over the place from hospital standpoint in this area. It's going to happen to medical groups right down the street. It's going to happen in the emergency departments; it's going to happen in ambulatory surgery, it's going to happen in home health. There are all these things that are going on that are independent of a unifying source. And the unifying source has to be within this office.

I agree completely with Michael. We have not -- we've sort of abrogated our responsibility

to streamline if we have multiple different sites for looking at this data.

MEMBER KARPF: The only way you're going to get down to definitions -- because it really boils down to definitions -- is, in fact, if it's done in one place also.

CHAIRMAN ENTHOVEN: Barbara.

MEMBER DECKER: I agree with the comments and would endorse that we should do that. I don't think it's specific just in this Paper, though, that all those different entities that

we're saying need to examine and set up and -- it's not just this.

MEMBER KARPF: That's why I raised the point that all of these blue ribbon panels need to be tracked to an integrating process.

EXECUTIVE DIRECTOR ROMERO: Right.

MEMBER KARPF: That new integrating process is whatever we call "OHNO."

MEMBER SPURLOCK: To help it along -- can you say in No. 2 "the Legislature should authorize the state agency" -- what we've done in other places, "The Legislature and Governor should authorize the state agency that supervises managed care to develop an advisory body" or "to develop a mechanism" -- maybe "a mechanism" is better than "advisory body" because that could be multiple

advisory bodies or whatever you want.

CHAIRMAN ENTHOVEN: You know, let me just say -- I mean this is really a very complicated thing. I am totally sympathetic we've got to get some unification.

I think that what we have today with the Legislative approach means, for example, PBGH and a lot of other people would like to have a risk-adjusted outcome study for coronary artery bypass graft surgery like the ones they have in New York and Pennsylvania. And the problem is they cannot get it through the existing process because

they can't get new data elements required. So what they do is, instead, they have to go out on their own channel and go to hospitals, which is what's happening now, and create an independent study. And I think we all feel there needs to be some coordination. But part of it is that there has to be some give on the part of the -- on this issue. There has to be a way of doing it. Otherwise we're going to continue to get this proliferation. That's why we need the regulatory instead of legislative approach.

MEMBER SPURLOCK: I don't think we're disagreeing with "A"; we're trying to modify B about where that happens. And part of the issue is simply definitional. PBGH can and is going to do that. I'm working with them to help it through the

hospital industry for hospital satisfaction surveys. And the reason we're doing that is because it's much more efficient to do it on a sampling basis, and we can do it that way much more effectively. And we may not do it forever, as we talked about it last time. We may do it for a few years and realize that there's something better to spend our money on.

So I think what we want to do is have that coordinated in that state agency that's looking at managed care because that's going to be the oversite for where everything's coming from

PBGH, from NCQA, from all other areas.

CHAIRMAN ENTHOVEN: It's like what we had in the Regulatory Organization Paper we wrote, what we want them to do with respect to quality audits, figure out what that's supposed to be and the appropriate period and then do it once for all users.

MEMBER SPURLOCK: Exactly.

MEMBER ZAREMBERG: Alain.

CHAIRMAN ENTHOVEN: Yeah.

MEMBER ZAREMBERG: Could I ask a question? I know we're discussing A-1 and 2, and B talks about developing the electronic data system to do this. And I don't know enough -- I can only look at some of the things that two state agencies

have tried with statewide systems. And it's not easy to start out from scratch a data system. I don't know where you are on it. But we've had DMV and Child Support systems cost a lot of money, and as a result, no return to the people. And I don't know where you are. But -- and the reason I say the two are tied together is because you can have the state agency mandate data that requires a great deal of electronic reporting. And I just don't know enough about it.

MEMBER KARPF: The electronic medical record may be someplace on the horizon, but I can't see it just yet after having invested huge amounts

of money and anticipating investing more money down the road. Hospitals have tried to do it. And some hospitals have been built without record rooms because they thought they were going to get electronic medical records. Now they have records all through the basements in a haphazard kind of way.

I don't think we can depend on that. But if you do have an agency that says these are the eight data elements that we want you to track and here's how they're defined and this is standardized, you can get this because we get those now. We've got to report them to Blue Cross; we've got to report them OSHPD; we've got to report them to 9,000 different people. The more organized it

is, the better the data is. Right now with no definition and 9,000 different people asking for 9,000 different pieces of information, you can't do an effective job of it.

MEMBER ZAREMBERG: I appreciate that. I'm just trying to determine the capabilities to do that. And you talk about things separate from electronic data collection, apparently. But B talks about that. And so I just look at the two of them together. And where you have one state agency mandating data and the other Recommendation talking about expanding your electronic data, I just don't know if it's feasible --

MEMBER KARPF: The electronic record is certainly a lofty goal. And I think we'll get there over a period of time. But that in and of itself isn't the rate-limiting step in doing good quality assurance, good CEI kind of processes. That can be done without the electronic record, and it could be done in an expeditious kind of way if everybody's looking at the same kind of information.

In the state of Pennsylvania what they did was they mandated the hospitals to take on an information system. That became very expensive. In New York, I don't think they mandated an information system.

MEMBER SPURLOCK: No.

MEMBER FARBER: Well, the (inaudible) Commission already took a pass at trying to mandate their system for quality assurance and was met with resounding defeat by the over 6,000 hospitals (inaudible).

MEMBER ZAREMBERG: And that's what I was concerned about here. I wasn't aware of that. But I guess in my theory, I just don't want to support that.

MEMBER DECKER: I'd like to mention we've used 15 of our 35 minutes.

VICE-CHAIRMAN KERR: Just realize we're not setting up a new system. This is something

that's been going for about 15 years.

Dave, maybe you want to say a few words.

MEMBER TIRAPELLE: We're simply saying that we're trying to make a more effective system so that every data element that gets subtracted and added -- we're the only state in the Union that does it this way. Instead of requiring that the Legislature at the Assembly and the Senate be involved and the Governor sign, we're simply saying like every other state in the Union, we present a group that has the ability to represent the hospitals (Inaudible.) --

MEMBER SPURLOCK: We're not debating (inaudible). We're talking about B; right?

MEMBER KARPF: It's a question of defining them and -- of picking them and defining them. In a proposal for a center of excellence that HIPC put out for bypass surgery, when we looked at our data, our physicians turned out to be very much interested in complications. They wanted to know what happened with their patients after they got in the hospital. They weren't as interested in co-morbid diseases at the front end. So when we looked at the data initially, it looked like our patients weren't very sick that came into our hospital, and we made them very, very sick. And we had to go back and pull all of that data out and go look through the definitions to really show

that once you risk-adjusted them, our mortality and our complication rate was really quite excellent.

So you need that definition to be able to compare apples with apples. And so it's both pieces: The data elements and the definition piece.

CHAIRMAN ENTHOVEN: Michael, does this get -- if we change B to say "The Legislature and Governor should authorize the state agency responsible for managed care regulation to convene an advisory body," and then at the end add to that paragraph "the agency should coordinate data requests to avoid duplication"?

MEMBER KARPF: Yes. For regulatory agencies and potentially health plans -- I think the more standardization we have, the better information we're going to get and the easier it's going to be for consumers to understand it.

CHAIRMAN ENTHOVEN: So "coordinate data requests from all users" or something like that?

MEMBER SPURLOCK: "Duplication from all requesters."

MEMBER FARBER: Or "conflict."

MEMBER LEE: "Coordinate" covers it, I think.

MEMBER ZATKIN: How would they do that? I mean requests from employers and purchasing groups, health plans. Maybe they could

limit the health plan's ability.

MEMBER KARPF: If you start working with Pacific Business (inaudible) Health and you start working with (inaudible), you start standardizing it.

MEMBER SPURLOCK: What happens is, in a health plan, everybody wants to benchmark. And when you start collecting this data from this health plan on this hospital and this data from this health plan, you can't benchmark. You don't have a standard. Exactly what Mike's talking about. So if you have a standard, it's valuable for everybody: For the health plans, for the

purchasers, for the public. Everybody benefits from that standpoint on that standard definition.

CHAIRMAN ENTHOVEN: I sort of picture this like the Regulatory Organization Paper where we described for the quality audits that the new regulatory agency takes the lead and convenes a meeting, that all of you people are requesting data, I want you to sit down together and we're not going to leave this room until we have, you know, agreed on certain things in order to --

MEMBER ZATKIN: I'm not saying it's not a worthy goal. I think that we're creating a responsibility for this new state agency that it may not be able to achieve.

DR. WERDEGAR: It's permissive the way

it's worded, and it could lead to a uniform -- there are some data that -- the ones that are essential to the state now could be widely used by all the other parties or it could be adapted to be used by all the other parties.

What Alain was suggesting is not a requirement. They don't set forth any requirements; they bring everybody together to see if they can decide on any -- some kind of a uniform data set so you don't have the nine or ten different ones all going at the same time.

MEMBER ZATKIN: Does that mean OSHPD

would go into this entity? Because that's where the expertise on data lies within the state of California.

DR. WERDEGAR: Well, I would hope so because you want to preserve the longitudinality of the records. I think we described some of the problems of changing some of the data elements even though one of co-morbidity and complications, if we achieve it, requires going to the Legislature. And there must be a better way of -- and a faster way of doing that that still pays attention to the cost considerations that hospitals have.

MEMBER KARPF: I'm not sure the Legislature is the best Body to decide what (inaudible) I believe in.

VICE-CHAIRMAN KERR: We just specify,

of course, that the state should become involved in areas only where there's -- or cases where there are no acceptable--

DR. WERDEGAR: People jumped around in the discussion. I thought, Clark, that some of the difficulty might have been with 2-B, the electronic data, which is --

MEMBER LEE: Did we reach closure on 1-A?

DEPUTY DIRECTOR SINGH: No, we haven't. Members, at this point in time --

DR. WERDEGAR: I just want to say that

the discussion's on 1-A and B, but somehow earlier the discussion veered down to 2-B and became a complicating factor, I think, because some might have thought that in order to achieve 1-A and B, you necessarily have to do 2-B as well.

DEPUTY DIRECTOR SINGH: Could I simply ask, Ms. Singer, do you have the amendment -- do you have the amendment language -- do you have the amended language?

MS. SINGER: I have some of it. I have "The Legislature and Governor should authorize the state agency" -- whatever the acronym -- "to convene an advisory body composed of providers, health plans, purchasers and consumers to evaluate specific data requests." Then following the last sentence "when feasible, the agency should

coordinate date requests to avoid the duplication of data requests."

CHAIRMAN ENTHOVEN: "Coordinate data requests for all requesters to avoid duplication."

DEPUTY DIRECTOR SINGH: "To coordinate data requests to avoid duplication."

MEMBER ZATKIN: If that's the amendment, then you've lost the concept that requests there will be a focus on looking at the cost and the value of each data element.

VICE-CHAIRMAN KERR: That's still

there.

MEMBER LEE: We haven't deleted everything.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: We're adding language.

MEMBER LEE: This is adding, not deleting.

DEPUTY DIRECTOR SINGH: Members, are we ready to make a motion to adopt Recommendations --

UNIDENTIFIED SPEAKER: I have one clarifying question, if I may.

Just in terms of clarity -- if I go back to what the original "A" said, I think what it says is that there's a state health data program. And the first question is: Does that entity request specific data elements for collection, or does it

pose the collection? The second part of the question, then, was the original read that the advisory body then evaluated it. My question is: Does the advisory body evaluate it, or does the advisory body review and approve it? I'm just trying to get clarity around the roles of the different parties in the process.

VICE-CHAIRMAN KERR: The advisory body would be the one that would review it.

CHAIRMAN ENTHOVEN: To review and approve.

MEMBER DECKER: Approve what?

VICE-CHAIRMAN KERR: Data elements.

MEMBER KARPF: Bring it to this new regulatory agency.

MEMBER ZATKIN: I have a problem. I think it should be the state agency.

MEMBER KARPF: It is the state agency.

MEMBER ZATKIN: The advisory body is not an accountable body. They're advising the state agency. To give an advisory body the authority to add and detract data elements, I think --

MEMBER KARPF: No, it should be the state agency.

MEMBER ZATKIN: But I heard it was the advisory --

CHAIRMAN ENTHOVEN: Yeah, yeah. Okay.

Okay.

VICE-CHAIRMAN KERR: We're going to amend it to the state agency.

MEMBER ZATKIN: The state agency should approve it, and they should make the Findings regarding cost and value.

MEMBER KARPF: Right.

MEMBER ZATKIN: And the advisory body should advise them on those elements. But there ought to be a specific finding made. And for each

data element, is this valuable or not? And what's the cost of doing it?

MEMBER KARPF: And can you do it.

CHAIRMAN ENTHOVEN: I'm just wording it --

MEMBER FARBER: Is it doable.

DEPUTY DIRECTOR SINGH: The Chairman has proposed language.

MEMBER KARPF: That is true for many of the blue ribbon panels. We have sort of thrown up in the air --

MEMBER ZATKIN: Most of them do not have the authority to impose the requirement. This one does.

CHAIRMAN ENTHOVEN: At the end of "A," we could say "The state agency should approve data requests, balancing costs and benefits."

MEMBER ZATKIN: "Make specific findings

regarding."

CHAIRMAN ENTHOVEN: And "make specific findings regarding costs" --

MEMBER ZATKIN: "Costs and benefits."

CHAIRMAN ENTHOVEN: Okay. "And make specific findings" --

DEPUTY DIRECTOR SINGH: Ms. Vorhaus, do you have that language.

MS. VORHAUS: "The state agency should approve data requests and make specific findings

regarding costs and benefits."

DEPUTY DIRECTOR SINGH: Members, are ready to vote.

MS. VORHAUS: That comes at the end of "A"?

DEPUTY DIRECTOR SINGH: End of B.

(Multiple speakers.)

CHAIRMAN ENTHOVEN: That's at the end of "A." Because there we're talking about the agency.

MEMBER RAMEY: I think that we can all see the sense of the universal data set that is more easily arrived at then having to get a Bill through the Legislature. The point that bothers me is that -- and the discussion has been somewhat connected is that we say that we're going to do this considering costs and benefits. But then we jump to 2-B --

(Multiple speakers.)

MEMBER RAMEY: Now, wait a minute. Because where is the consideration of the costs and benefits in that? I mean we're making an immediate leap. And if this agency is going to make the same leap that this Body seems perfectly prepared to make, then we're going to increase the costs of health care in this state by hundreds and millions of dollars.

MEMBER ZATKIN: This body has not evaluated the cost of doing 2-B. An agency would have to.

MEMBER RAMEY: I guess we do everything without evaluating the costs of anything, which is one of the problems with this Body.

MEMBER ZATKIN: We haven't voted on that.

MEMBER RAMEY: But the point is is that -- my point is that if we're going to make a judgment here that B is in line with these principles of costs, which we seem to be heading towards doing -- or you're going to vote against me is what you're saying.

MEMBER ZATKIN: If it's worded the way it is, I am.

MEMBER KARPF: Yeah, I think that's right.

MEMBER FARBER: Wait until we get

there.

MEMBER KARPF: John, we already do "A"; it's a question of doing "A" better. And then we have to deal with B. If we could get to B, that would be great. Whether we can get to B (inaudible).

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Members, if we could have a motion to adopt Recommendation A --

MEMBER LEE: So moved.

MEMBER RAMEY: I won't vote for 1 unless I know B isn't going to pass.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: It's 1-A and 1-B. Is there a second.

MEMBER DECKER: Second.

DEPUTY DIRECTOR SINGH: Those in favor of adopting Recommendation 1-A and B please raise your right hand.

Those opposed please raise your right hand.

Twenty-one to zero. The Recommendation is adopted.

CHAIRMAN ENTHOVEN: Okay. B.

VICE-CHAIRMAN KERR: Electronic medical records. We talking about this a lot. We've changed what we had before. We re recommending the state agency become involved with the existing

effort that's going on that's going on. I do want to make a friendly amendment and add to that list of PBGH, (inaudible) and so on, CHA since they are participating. So please add that in so they actively become involved.

Second part is to set a deadline -- a target to try and put these in. I've talked to David Hopkins at Powers (inaudible). These are the

people at PBGH. They strongly encourage us to please put that deadline in. They say they plan to counter (inaudible) by the year 2000. I think 2002 to 2004 is reasonable. And they need something to push the effort to make it happen.

We stress in C the importance of having privacy and confidentiality respected. And we talk about the importance of establishing data security and standard language and definitions in four (inaudible).

CHAIRMAN ENTHOVEN: Okay. Let's start with 2-A.

MEMBER FARBER: I'd like to know who's going to pay for it.

MEMBER NORTHWAY: PBGH wants it, PBGH pays for it.

VICE-CHAIRMAN KERR: I believe for those of you who are involved in this that PBGH has agreed to pay part it if they're involved in it, and that it's a cooperative effort that seems to be

moving along pretty nicely at this point.

MEMBER KARPF: Talking from personal experience, it's certainly a lofty goal, one that we are committed to at our institution. And we are investing tremendous resources. The capital budget for IS infrastructure for this year in my system is $15 million. It's going to be $15 million next year; 15 million the year after that; 15 million

the year after that. So we've essentially committed ourselves to $100 million spread out over a bunch of years to get a paperless electronic system. Can I tell you we're going to get there? Absolutely not. That is a goal for us. But I've not seen an institution achieve that. So it's hard to legislate that or mandate that through the system. And for smaller systems than ours, until there is something that's off the shelf, it becomes next to impossible.

MEMBER GILBERT: Michael, if you have that much money, I'm taking back my support for the Academic Medical (inaudible).

MEMBER KARPF: That's the only way we can compete. We're an information business.

CHAIRMAN ENTHOVEN: Because in the long run, this is going to bring the cost down.

MEMBER KARPF: That's right. It's the only way you can -- we are committing ourselves to become quantitatively defined and do medical

management in a quantitative approach. For us, this is the future, so we must invest in it. But how long it's going to take us to get there, God only knows.

MEMBER FARBER: For smaller medical centers -- and I don't -- Washington is one. But coming from the hospital district background with

65 hospital districts in the state, most of them small rurals, this is not even within the realm of reality for a small rural hospital.

CHAIRMAN ENTHOVEN: Is there a 2-A now or --

MEMBER FARBER: I'm talking about electronic records. It's just not possible. It's a real stretch for a modern medical center like Washington in the San Francisco Bay area.

You may have $15 million a year to put into information services, but we don't. And a small district hospital has nothing to put into this.

So I'll go back to my original question. I guess it all revolves around of (inaudible). Who's going to pay for it? I think it's great. But we don't have any money to do this.

MEMBER ZATKIN: We are going to do this, I've been told. However, the issue is not whether we're going to do it or Nancy is not. I think the issue is whether it is appropriate.

Public policy for the Legislature to mandate a specific approach not to what data is to be provided but how it's to be provided. And that's my concern. I agree it's a great role. We're going to do it. We are doing it. But this is a basic issue about the role of government in mandating it. If purchasers want to mandate it,

they should do it. I think they have a lot of leverage. Well, it's -- I mean if the Legislature can mandate the hospital to do it, why can't they turn around and mandate the Bank of America to put in approach to electronic -- now, maybe they did that and I didn't know about it.

MEMBER DECKER: Just to trump Michael's Right 15 million a year, we're spending $200,000 million at Southern California edison to put in the new data systems for deregulation of electricity -- $200,000 million; okay? So we have to pay it.

MEMBER ZATKIN: Is that mandated by the Legislature.

(Multiple speakers.)

VICE-CHAIRMAN KERR: I know there's many concerns about issue cost. In terms of quality of care, it's really sort of like flying an airplane without any computers, without any sort of -- anything else. In terms of the alerts that are available, in terms of the decision support, the reminders, the advancements of evidence-based

medicine, it's almost a crime not to have these in place now. I realize there's a lot of steps to be done. I think what we're not seeing here is mandating the approach. We're saying the state should work with the existing group which has all the major stakeholders (inaudible). What we're

saying here is we're hoping to set a target deadline to help push the effort along, which will have a terrific benefit in terms of consumers and patient safety -- a very, very major change (inaudible).

CHAIRMAN ENTHOVEN: I just think there's huge amounts of cost avoidance here, if we could get to this here. With our auditing of (inaudible), you would be able to do that electronically if you had the counter data.

MEMBER HARTSHORN: Mr. Chairman -- just a second. I'd like to say something. I couldn't agree more with what Clark was saying. If you look at the fax about the health care industry, we have underspent in this area for years. I mean we're spending one to two percent of sales where other industries spend five to ten percent. We not only have to catch up, now you're saying we have to have a state-of-the-art system. I used to work for an organization of eight hospitals, four independent medical groups, IPAs. We had an assessment done. It was $250 million, seven years to implement, and

then we probably wouldn't have it.

So I think it's a lofty goal. It's admirable. There's a lot of things going on in data. In fact, some of the fastest growing companies now are those that are working in this area. And many provider systems are waiting until

they develop and we can just buy the system rather than developing our own. But I think we'd look foolish, frankly, if we set dates and how we were going to do it and by when. I mean it's an overwhelming problem that I can't even fathom.

One more thing. We did a survey. Twenty-five percent of physicians don't even have fax machines in their office. We were just trying to connect with everybody so that we could talk to each other. Forget about that.

MEMBER SCHLAEGEL: In the Information Data Summary aren't they talking about the problems that Nancy brought up about how we keep the data systems moving and who's going to pay for it? It seems to me that was a whole topic that they were going to cover.

MEMBER SPURLOCK: One of the work groups in the Data Summary that's been fronted by the California Health Care Foundation -- this is what we call the "business reason" or the "business mandate" to do this. I think we're exploring that.

One of the key principles that I think

we've adopted is the notion that this has to evolve and that you can't sort of pick the time in the future and say "This is what we'll evolve to." It's like saying, you know, when's the next time we're going to go to the moon or to Mars and whatever's

going to happen by that time. It's nice idea, but it just can't happen.

But the business case is an extremely important part of the data summit, the group that Clark alluded to earlier; that's up in No. A. And we're dealing with that. So I know that we can have a push and we would love to have a target and dates and we all want to set those for ourselves. But I think requiring it for the state authorities is a mistake.

MEMBER KARPF: It will change the question of health care because Kaiser will do it and other large groups will do it because they do view it as a business decision. That's the only they can deal with medical management issues. But it will drive independent providers, independent hospitals out of the realm of possibility.

MEMBER SCHLAEGEL: That's a significant issue.

MEMBER SPURLOCK: What it drives, it drives consolidation an a return to Wall Street. I mentioned that before. But the only way to get the capital to do this is in the public sector and Wall

Street. You can't float a Bond. You have to have enough money to be able to do this. So it's going to drive consolidation and drive people in that direction.

DR. WERDEGAR: Well, this is the point

I was trying to make earlier that I was afraid would upset 1-A and 1-B, which now have passed, that everyone would concentrate on 2-B and think that it was somehow a necessity to have 1-A and 1-B. And, Clark, I'm sorry I didn't have a chance to talk with you about this earlier.

I think 2-A is, as the Task Force recommends, bringing people together to talk. That would be perfectly all right. I think everyone is having a problem with B because it's "regulatory authority should require that." And I think if 2-B could be recast in terms of bringing people together to talk about some uniformity, some ways of reporting in a consistent way, doing network so they don't all have different -- completely different architectures and data collection --

VICE-CHAIRMAN KERR: The corner here with the hungry stomachs have been working on a compromise. So here's Barbara's proposition.

MEMBER DECKER: I don't think it quite fits yet. But instead of saying "require" in 2-B, first line, how about if we try for "The regulatory authority should strongly encourage by providing

leadership and coordination" and keep that kind of thought.

MEMBER FARBER: You're leaving out the very essential ingredient, which is capital.

MEMBER WILLIAMS: And management skill.

DR. WERDEGAR: I think that phrase that was used earlier could be used here again with a view to the cost benefit. It also talks about size of facility and resources. That these are discussion items; these are not requirements.

CHAIRMAN ENTHOVEN: Let's see.

MEMBER DECKER: We're out of time.

CHAIRMAN ENTHOVEN: Let's see. What do we do, Clark?

VICE-CHAIRMAN KERR: I think this is something we're split on, obviously. If there's obviously a consensus in the group -- we don't want the "required." There's consensus that it's very important. Are we agreeable that it should be "strongly encourage"?

CHAIRMAN ENTHOVEN: Okay.

VICE-CHAIRMAN KERR: And also provide the leadership -- help provide leadership and coordination in this effort.

MEMBER SPURLOCK: Is that what we're saying?

MEMBER BOWNE: What about taking out the date?

VICE-CHAIRMAN KERR: I would prefer to leave the date as a target.

MEMBER DECKER: I know you would.

MEMBER SPURLOCK: I think the other

thing (inaudible) architecture because that's describing a technological solution that may not -- I think the whole idea is easy data exchange. I think that's the principle you're trying to get rather than --

CHAIRMAN ENTHOVEN: We can just take away the words "open architecture" and just say "systems that permit based on a system that permits easy sharing and exchange of data."

MEMBER FARBER: Yeah.

MEMBER SPURLOCK: "Based on a system".

CHAIRMAN ENTHOVEN: "That permits easy share and exchange of data."

MEMBER SPURLOCK: "Systems that permit," actually. It may be multiple systems.

MEMBER SPURLOCK: "Be phased in," period.

CHAIRMAN ENTHOVEN: "Be phased in."

DEPUTY DIRECTOR SINGH: Ms. Vorhaus, do you have those amendments.

MS. VORHAUS: I think so.

MEMBER SPURLOCK: Then it's also "encourage" and -- what's the wording?

DEPUTY DIRECTOR SINGH: I think that

was at the beginning of that.

MS. VORHAUS: I have "The regulatory authority should strongly encourage by providing

leadership (inaudible) the component electronic medical records (see starting with the counter data) based on a system that permits easy sharing and exchange of data be phased in, depending on the size and resources of the medical groups, health plans, clinics and hospitals."

MEMBER LEE: Somewhere in between "phased in, hopefully by" so at least there's some period in there.

VICE-CHAIRMAN KERR: I'll be honest with you, I think if you don't have a date out there, you might as well forget the whole thing. That's my feeling. If you don't put a date in there, you might as well forget the whole thing.

MEMBER KARPF: I think that's wrong, Clark. I think that's wrong. Because that what you accomplish is having this new agency focus on trying to get some uniformity upfront rather than afterwards. So I think that without the date, there's still some real value in giving this agency a mandate to explore possibilities.

DEPUTY DIRECTOR SINGH: Members, can we just do a quick straw poll vote on whether or not to keep in the date.

Those in favor of keeping the date

deadline in please raise your hand.

MEMBER DECKER: As a target?

DEPUTY DIRECTOR SINGH: As a target.

Please raise your hand.

Those opposed?

We have a 13 to 7 -- so we'll keep that in as a target. By that target date.

CHAIRMAN ENTHOVEN: Well, with a target --

MEMBER LEE: Any other changes to 2-A through D?

DEPUTY DIRECTOR SINGH: Members, are you ready to make a motion to adopt Recommendation 2-A through D as modified.

UNIDENTIFIED SPEAKER: So moved.

DEPUTY DIRECTOR SINGH: Is there a motion.

UNIDENTIFIED SPEAKER: Moved.

UNIDENTIFIED SPEAKER: Second.

MEMBER KARPF: Do we ask the federal government to pay for it if we're going to ask them to standardize it, too?

DEPUTY DIRECTOR SINGH: Those in favor please raise your right hand.

Those opposed.

The Recommendation is adopted 19 to 2.

VICE-CHAIRMAN KERR: Hopefully we'll speak a little faster.

The next one A and B are simply saying that we want to have data collected not only at the

health plan level but as feasible at the hospital, clinic, medical group, IPA, (inaudible), home health levels. And that the other -- the second point in B essentially is that the authority will be involved as necessary. But essentially the idea there is that the state will not duplicate efforts in the private sector. In other words, the state would take initiative in these areas in cases where no acceptable private effort exists. So, again, attempting to avoid duplication.

DEPUTY DIRECTOR SINGH: Discussion? Mr. Lee.

MEMBER LEE: I circulated a memo (inaudible) additions to Section 3 that I'll hold over tomorrow for the oversite discussion. They could have gone in either one. In regards to the lateness of the hour, people can make sure they looked at it, and I'll bring it up then.

DEPUTY DIRECTOR SINGH: Is there any further discussion?

DR. WERDEGAR: I have a concern about B, which basically has data that should be publicly available mainly being -- it says to have the private sector do that, and then only if the private sector isn't doing that would there be the public sector doing it. And I feel that if you're

going to have data that's to be made publicly available, the best way of assuring that is to have

a public body collecting it. So I would strike 2-B myself, if I were a voting Member.

MEMBER LEE: If I may. That's exactly the concern that my suggestions get at is to make sure that data, whether it's collected by the private or public is made public including the process by which. And it does address that concern that mine comes up.

DEPUTY DIRECTOR SINGH: Is that an amendment?

MEMBER LEE: No.

MEMBER SPURLOCK: I think there's a little mistake in the concept of collecting. One of the things we're working on at the Health Data Summit is that you exchange information. You don't store it at one place. There's not a data repository. The data exists sort of in a virtual network using kind of the Internet processes where you have pieces here and pieces here and they can be exchanged easily across the systems so that we're all talking in the same language. If you want to find pharmacy information, you can find it from the health plan level, hospital level, physician group level. You can find it at any point. But it's not stored in one place except for the pharmacy that gave the prescription.

So to think about collecting all this

data and putting it in one warehouse I think is a mistake. It's going to cost billions of dollars to that. But if we have tiny little pieces with each of them storing their little piece at their little place and then sharing it, we have a much better system in the long run. I think that's what we're trying to move for in the Data Summit.

MEMBER O'SULLIVAN: Who is that data available to? If I want to get that data, how -- I know now where I can go and -- is there a process for me to --

MEMBER SPURLOCK: The appropriate person, at the appropriate time, at the appropriate place. That means if you're in the Emergency Department and you need the information on the pharmacy data, you have a keying ability to unlock that data, only those people. You're not -- the health plan doesn't necessarily have that data unless it's (inaudible).

MEMBER O'SULLIVAN: Then nobody can go in there and look at all the data (inaudible).

MEMBER SPURLOCK: Exactly.

UNIDENTIFIED SPEAKER: There's software today on the market that you can buy that builds the firewalls and just authorizes certain people to go in and get the data.

UNIDENTIFIED SPEAKER: Once you get it,

it's erased from that little cell.

MEMBER SPURLOCK: The confidentiality issue is a huge issue, and I think what you're alluding to is that. I think that we need to build those protections in there. I think that's alluded to in the other information. And we can strengthen this one here if necessary. But the whole notion of a collection and a repository is a mistake.

MEMBER O'SULLIVAN: I'm asking, once this data has all been -- starts moving and we're gathering it, it's happening, how are we going to analyze it and make broad policy decisions based on the new information we have if it's so hard to get to?

MEMBER SPURLOCK: I'm not sure what broad policy decisions you're making. I meant from a contractual basis, if we want to look at centers of excellence, for example, and we want to find out -- if I'm PBGH or if I'm a health plan, I want to find out which hospitals have had the best results in this risk-adjusted way using this data, we pull that up because they have access to that kind of information. We develop special keys for those people to get that kind of information, that kind of reporting system out.

I mean it's hard to envision completely who's going to have the keys to what information. But there will be a lot of protections, as Terry

alluded to, to make sure that it's only the appropriate people that get appropriate keys. And there will be information about who's put the key in where to find out so that we have some trails to make sure that was all confidential and safe.

So there may be multiple answers as to who's going to need it for general policy information.

MEMBER DECKER: We're now 12 minutes past our 35 minutes. And the restaurant is closing.

MEMBER KARPF: There's a hierarchy to how you can get data. It's taken OSHPD a couple of years. It took the state of Pennsylvania several years to be able to get mortality data by hospitals where they have hundreds of cases. And it took several years to get to the point where you could look at groups of surgeons and say this is the mortality for groups.

If you're going to try to get down to data, is this a good cardiologist or bad cardiologist, one, the data is not available because there is no electronic record system at that level. Second of all, you get down to some very small numbers where risk adjustment becomes very, very difficult. So you can't get to the level that you want until you've gotten past getting much larger scale data over a period of

time and trended it and start drilling down. You can't get down to the practitioner level or the five-man group level at this point in time.

MEMBER SPURLOCK: That's why B has to be in there.

MEMBER O'SULLIVAN: I'm concerned this is so much in the private sector that we'll never get to it.

VICE-CHAIRMAN KERR: C, the underlined part, simply says that if the regulatory agency doesn't disseminate this information, we'll make sure that the private sector does so and that it's easily accessible.

So what we're saying is that the information will be available. That's what's important. Whether it comes from the private sector or the state is not as important. It's the fact that it will be available.

I think, Dave, in response to your concern, we're not saying the state shouldn't do something; we're just simply saying that if the private sector is doing something in an acceptable manner, the state shouldn't duplicate it. That's essentially the idea of B.

DEPUTY DIRECTOR SINGH: Is there further discussion? If not, could we have a motion to adopt Recommendation 3-A and B.

MEMBER LEE: Move to adopt.

MEMBER ZATKIN: I did have a point. This ought to relate back to the same criteria that we applied previously in terms of cost and value, and it doesn't say that.

DEPUTY DIRECTOR SINGH: Do you want to propose an amendment?

MEMBER ZATKIN: Yeah. I would propose that the same criteria that --

MEMBER KARPF: Balance cost and --

DEPUTY DIRECTOR SINGH: Yes.

DEPUTY DIRECTOR SINGH: Where would that be so that Ms. Vorhaus can note that? Where are you proposing that language?

MEMBER ZATKIN: As a proviso. Provided that collecting and disseminating the data, that's specific -- that findings are made regarding the cost, value and whatever the other one was of collecting and disseminating --

VICE-CHAIRMAN KERR: That's a friendly.

DEPUTY DIRECTOR SINGH: To B.

MEMBER LEE: No, it's in "A."

DR. WERDEGAR: Is discussion still going on? It's the last phrase of 2-B that is of concern to me. I wonder if it could be deleted starting with "and to take initiative in cases where no acceptable private sector effort exists" and simply have the sentence that the Task Force recommends the authority be aware of, participate

in, actively help where possible ongoing private sector efforts to develop and distribute these data, period.

MEMBER LEE: That's fine.

MEMBER NORTHWAY: So moved.

MEMBER O'SULLIVAN: Second.

DEPUTY DIRECTOR SINGH: Who moved? I'm sorry, who's made the motion to adopt? Northway. Thank you. It was seconded by Ms. O'Sullivan.

Those in favor please raise your right hand.

Those opposed?

Seventeen to one. The recommendation has been adopted.

VICE-CHAIRMAN KERR: I'm going to make a friendly amendment to No. D, which essentially sets up a series of pilot studies. I'll ask that we also have that same concept of balancing the cost and value that we discussed before. That would all be included in this one as well.

MEMBER KARPF: Are you specifically recommending these data elements be collected?

VICE-CHAIRMAN KERR: No. We're simply saying that the group of stakeholders, which includes consumers, purchasers, providers and vulnerable population (inaudible) plans, medical groups, health policy experts, that they consider a

series of pilot studies that might include, may include the following. These are ideas. They're not requirements. They may include. These were a series of ideas that may be included. The idea behind that is that those pilot studies that were successful and were proven to be useful, that those would then go on a statewide basis after they have proven themselves on an ongoing basis.

DEPUTY DIRECTOR SINGH: Any discussion?

MEMBER LEE: Move adoption.

CHAIRMAN ENTHOVEN: Second.

MEMBER KARPF: Are we putting "A" to find whether it's economically feasible?

VICE-CHAIRMAN KERR: We're amending it to include the balance, the cost, the value of each of these.

CHAIRMAN ENTHOVEN: Then you have to read some words to Carol.

VICE-CHAIRMAN KERR: Just take what you had from the prior ones.

MEMBER ZATKIN: There should be specific findings regarding the value and the cost of conducting each study.

VICE-CHAIRMAN KERR: Right.

DEPUTY DIRECTOR SINGH: Those in favor of adopting -- now, Recommendation 4-A, B, C and D, on the next page, please raise your right hand.

VICE-CHAIRMAN KERR: We're voting,

guys. We're voting.

DEPUTY DIRECTOR SINGH: Please raise your right hand. I'm noticing that there were new votes over here.

Those in favor please raise your right hand. I'm going to count again, Members. Please raise your right hand. Don't put them down until I tell you. I count 15.

Those opposed?

Fifteen to six. The motion fails.

MEMBER LEE: Lee just do notice that we might bring this up again tomorrow (inaudible).

(Multiple speakers.)

MEMBER FARBER: No, you voted on it.

VICE-CHAIRMAN KERR: I'm going to ask for reconsideration.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: Members, Members, Mr. Kerr is asking for reconsideration. We need a second and a simple majority vote. The reconsideration would be that the vote would then be -- this vote would then be taken up tomorrow when there are more members here. So Mr. Kerr has moved. Is there a second.

UNIDENTIFIED SPEAKER: Second.

DEPUTY DIRECTOR SINGH: Okay.

MEMBER NORTHWAY: May I ask what the vote was?

DEPUTY DIRECTOR SINGH: It was 15 to 6.

MEMBER GILBERT: How about if we adjourn and pick up both 4 and 5?

MEMBER DECKER: Second.

MEMBER GILBERT: I think we're getting to the point where we can't even read the stuff, and we're getting exhausted so we don't know what we're voting on.

DEPUTY DIRECTOR SINGH: Let's just finish the reconsideration, and then we can vote to adjourn or what have you.

Those in favor of reconsidering Recommendation No. 4 tomorrow please raise your right hand. This requires a simple majority vote.

MEMBER LEE: (Inaudible) I won't vote to adjourn.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: We need a simple majority to reconsider. I'm sorry.

Opposed to reconsideration tomorrow?

It's 15 to 6. That means we reconsideration wasn't granted.

(Multiple speakers.)

DEPUTY DIRECTOR SINGH: No, it's 16.

(Multiple speakers.)

CHAIRMAN ENTHOVEN: We're going to have just a brief administrative announcement about

food, and then we're going to adjourn for the night. Thank you for your good humor.

Phil.

EXECUTIVE DIRECTOR ROMERO: Not to delay you from your eating, Steffanie (inaudible), who paid for our lunches, my long-suffering assistant, is about $40 short. I'd rather she not also be a poor long-suffering assistant. You know who you are. If you have not paid for your lunch, please come up here and do so. And if you do not know, the cover sheet on your lunch bag indicated the amount. And we would ask that tomorrow you turn them in when you pay.

See you tomorrow at 8:30.

(Discussion held off the record.)

(Multiple speakers.)

UNIDENTIFIED SPEAKER: Yes, I just wanted to address the subject of academic medical centers. Although Dr. Karpf knows academic medical centers from the inside out, it's hard to agree that financial support for medical education had never been clearly defined. Since after all, there was a time before there were private insurers, before there was Medicare, before there were residencies.

When you talk about medical education in hospitals, you're talking about residencies. These residents spend 80 to 120 hours working in the

hospital for the same wages as a registered nurse. That is obviously a net contribution. The funding for the academic medical center is coming from the community with its will; excellence in medicine is the highest expression of human endeavor and from the residents and the residents' future patients.

The taxpayer is being put in the position of having to pay the ready-to-serve cost of the hospital and the research and development cost of the academic hospitals, which are in the forefront of medical progress, in order for private insurers to make a fortune selling the incremental advanced technology to the taxpayers who can't afford to self-insure and are denied brokerage and reinsurance by the government to which they pay their taxes.

I would like to ask the Task Force to consider asking the state to broker the health insurance so that those $5,000, which have already been paid by every insured person in 1991, 2 and 3 could be available to pay the medical expenses of those who need a tertiary care hospital in 1994.

Thank you.

CHAIRMAN ENTHOVEN: Adjourned.

(The hearing was adjourned at 8:23 p.m.)

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R E P O R T E R' S C E R T I F I C A T E

STATE OF CALIFORNIA)
) SS.
COUNTY OF SACRAMENTO)

I, SANDRA L. HOPPER, a certified shorthand reporter, do hereby certify that the foregoing 331 pages comprise a full, true and correct transcription of the proceedings had and the testimony taken at the hearing in the hereinbefore-entitled matter.

Dated this 15th day of December, 1997, at Sacramento, California.

SANDRA L. HOPPER, C.S.R.
C.S.R. NO. 7110